PROJECT HOPE

IMPROVING THE HEALTH OF GUATEMALA'S MOST VULNERABLE POPULATION: MIGRANT WOMEN AND CHILDREN IN THE BOCA COSTA REGION OF SOUTHWESTERN GUATEMALA

Third Annual Report

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TABLE OF CONTENTS

Attachments

1. Map of project implementation areas
2. Organizational Chart
3. Basic Health Care Units Studies
   - 3.1 Performance of Health Promoters
   - 3.2 Client Satisfaction
   - 3.3 Situational Assessment

ACRONYMS

ADISS	Association for the Development of Integrated Social Services (an NGO)
AMNE	Essential Maternal and Newborn Care
APAES	an NGO, Association for the Assistance of PLWA
CA	Cooperating Agency
CBDA	Community Based Distribution Agent
CS	Child Survival
DIP	Detailed Implementation Plan
ETANA	National Technical Advisory Committee for IMCI
GTI	Interagency Technical Group
HU	Health Unit
IMCI	Integrated Management of Childhood Illness
IMCI-C	Community-Based Integrated Management of Childhood Illness
IGSS	Guatemala Social Security Institute
JHPIEGO	John Hopkins Program of International Education for Gynecology
MOH	Ministry of Health
RH	Reproductive Health
TBAs	Traditional Birth Attendant
LQAS	Lot Quality Assurance Sampling

INTRODUCTION

Since September 30, 2001 Project HOPE has conducted the Child Survival program (CS-18) "Improving the Health of the Most Vulnerable Population in Guatemala: Migrant Women and Children Living in the Boca Costa of the South West of Guatemala" (Cooperative Agreement FAO-A-00-97-0030-00), which will end September 29, 2005. This program is a four-year extension of the CS-13 Child Survival program, 1997 to 2001.

The intervention area of the program is in the Departments of San Marcos (SM), Quetzaltenango (Q), Suchitepequez (Su), Retalhuleu (R), and Solola, (So), covering a total of 25 municipalities of the Boca Costa and 4 municipalities of the highlands, which are the origin of the migrants.

The target population is 330,000 beneficiaries, including 162,304 children under 5 years of age and 171,959 women of reproductive age, who live on the farms or in communities near them, who come to work in these areas during the coffee harvest season. They are groups of the population who have little access to health services.

The current program is focused on increasing access to health services and education for the population via local partners including the Ministry of Health (MOH), the Guatemalan Social Security Institute (IGSS), 3 local NGO's involved in providing basic health services at the first level of the Integrated Health Care System (SIAS), in the intervention area (these are ADISS, the Red Cross and Anacafe Funrural), and with the support of the owners and farm administrators.

With the goal of improving the quality of health care, the program helps the partners strengthen their technical capacity and improve the skills of the Institute's staff in national health strategies – Integrated Care of Common Childhood Illnesses (Clinical IMCI), Community IMCI and Essential Maternal and Newborn Care (MNC, which is promoted by JHPIEGO).

To increase accessibility to health services they supported partners in operationalizing national health policies such as Care of the Migrant Population and increasing coverage of basic health services via the implementation of 155 health posts so far, 91 of them are located on coffee plantations and 63 are in communities near the coffee plantations, which are served by Rural Health Promoters.

They seek to improve the response capacity in the community by training and monitoring the volunteer personnel: rural promoters at the basic health posts who provide care for the morbidity of families, especially migrant and resident children, they conduct informational and health promotion activities, and to community promoters who provide health education as well as to promoters who distribute family planning methods and to midwives who assist with pregnany and births and give postpartum care to mothers in the intervention area.

The partners receive support from the Program to strengthen the Departmental Health Boards, the formation of Master Trainer Centers at the departmental and municipal level and the development of health messages to be transmitted by radio stations.

One of the greatest challenges the project has had to face is the dramatic fall in the price of coffee which also means a fall in work offered to the migrants and at the same time a fall in income of the families, which negatively affects the health of the population. The numbers of migrants arriving at the farms to work has fallen considerably year after year, and it is estimated at about of 25% of what was predicted, which has meant that the activities of the program are focused on resident population who live in communities very far away, where there are no health services. They have also reinforced prevention and educational activities in the communities of the highlands which are the source of the migrants. We continue working to maintain the number of health posts (182) which were reported in the mid-term evaluation, and many promoters have located the health units in their own houses to be able to continue caring for the resident population who require their services.

Due to the same economic crisis caused by the fall in the price of coffee, the Ministry of Health has faced limits to fulfill its promise to continuously re-supply the health units, nonetheless many health services are prioritizing the providing of medicines to these units since they are considered as another manner to widen coverage which will help them increase their service production.

Project HOPE itself is not supposed to provide direct care services to the migrants or the residents in the target area, the emphasis is placed on providing support for building capacity of its member agencies.

In February, 2005, an addendum to his report will be sent to USAID containing information on care provided to the migrant and resident population during the coffee harvest season of 2004.

I. A. The main accomplishments of the program and what it has done well.

The primary project achievements include:

- One of the most important successes of this program has been the strengthening of the link between local partners of the MSP, the IGSS, Funrural of Anacafe, the MNH Project of JHPIEGO and other NGOs with a presence in the intervention area and the private sector of the coffee farms. This strategy is indispensable to build capacity and promote sustainability of program activities. The program has contributed to achieving, at the national level, an improvement in the health needs of the migrants and residents of the coffee farms and the communities nearby.

- Credibility and Technical Assistance: The credibility of Project HOPE vis-à-vis our counterparts is very high since we have strengthened the technical capacity of their staff. HOPE has worked very hard to support the member institutions in the implementation of national health strategies for which it provides excellent technical assistance and maintains close follow-up of the promises made in the joint action plans which means the members have confidence and value the participation of HOPE in the Health Areas. HOPE provides technical assistance to members of the Inter-Institutional Coordination with members of the program in planning and implementation, in training, control of information and in monitoring and evaluation.

- We have also achieved the strengthening of partner organizations, which is one of the most important strategies of the program, and we have supported the MSP, the IGSS and NGOs to strengthen their technical institutional capacity. Looking for sustainability, HOPE as worked very hard to transfer all responsibilities for training and monitoring to member groups, via the cascade system. (See Table 1.)

- Project HOPE has maintained its participation in the Inter-Agency Technical Group (GTI) which is made up of the MSP and international agencies for identification, design and reproduction of basic health messages oriented towards changing behaviors in mother and child health, also the local level is supporting the Health Districts to translate these messages to Mayan languages. HOPE staff are members of the Committee of Technical Advisors to implement the AIEPI strategy at the national level.

- Project HOPE has a good relationship with the coordinator of the national program of care for migrant populations at the MSP and with the representative for the IGSS in charge of migrant affairs at the national level. Recently they held a workshop of lessons learned at the national level, and representatives of the member institutions participated and shared their experiences. They presented lessons learned in each Health Area and committed themselves to improving communications and the information system as well as to strengthening the relationships between areas to continue working in favor of the resident and migrant population of the Boca Costa.

- Immediately after the mid-term evaluation of the program, which took place in November 2003, we developed an Action Plan based on the recommendations of the

Evaluator which gave emphasis to preventive health at the community level via promoters, midwives and the involvement of the organizations which form the departmental and municipal boards of health to achieve an improvement in education at the household level.

- HOPE has supported member institutions to strengthen knowledge and skills in modern techniques of supervision and monitoring. In April 2004 we held an international workshop on applying the Lot Quality Assurance Sampling (LQAS) aimed at epidemiologists in the Health and Social Security Areas, supported by staff from HOPE Center and from HOPE Nicaragua. Later they organized repeats of this workshop at the departmental level in each Health Area.

- In September 2004 our LQAS round was held jointly with the members to provide follow-up on the 12 indicators of health at the household level which in the midterm it was reported were very low compared to the baseline. The attached study shows an apparent increase in all indicators (See Section IV –B).

- Jointly with the MOH and the IGSS a study was performed on the actual situation of the basic health units which function on farms and communities near the farms to obtain current information which could be used to identify those which could be sustainable at the end of the program.

- We also carried out a monitoring study of the work of volunteer personnel who care for children and mothers using the AINM-C strategy in the basic health units, to identify those aspects which should be strengthened via supervision and tutorial help.

TABLE 1: Training Activities Completed Through October 2004

A. Teams of Facilitators: The number of teams of facilitators trained in handling cases of infant disease and in prenatal and obstetric care.

Department and Municipal level	IMCI Objective	achieved	%	IMCI-C Objective	achieved	%	Reproductive Health Objective	achieved	%
MOH San Marcos	13	13	100	13	6	46	8	6	75
MOH Quetzaltenango	8	8	100	8	4	50	5	3	60
MOH Suchitepéquez	9	6	66	9	2	22	5	3	60
MOH Retalhuleu	2	2	100				1	1	100
MOH Sololá				1	1	100	0	0	0
Social Security	1	1	100	1	1	100	1	1	100
ONGs	4	4	100	4	1	25	1	1	100

B. Health Personnel: The number of official personnel trained in handling cases of infant diseases and in prenatal and obstetric care.

Department and Municipal level	IMCI Objective	achieved	%	IMCI-C Objective	achieved	%	Reproductive Health Objective	achieved	%
MOH San Marcos	150	127	85	150	92	61	150	156	100
MOH Quetzaltenango	60	146	243	60	25	42	60	47	78
MOH Suchitepéquez **	90	44	49	90	20	22	90	80	89
MOH Retalhuleu	10	11	110	10	22	220	10	7	70
MOH Sololá	5	14	280	5	18	280	0	0	0
Social Security	90	12	13	90	12	13	90	67	75
IGSS **									
ONGs	50	64	128	50	72	144	50	8	80

Promotors: The number of promoters trained in handling cases of infant diseases and Reproductive Health.

Department and Municipal level	IMCI Objective	achieved	%	IMCI-C Objective	achieved	%	Reproductive Health Objective	achieved	%
MOH San Marcos	----------			300	210	70	300	255	85
MOH Quetzaltenango	----------			150	71	47	150	46	31
MOH Suchitepéquez	----------			450	159	35	450	289	64
MOH Retalhuleu	----------			**25**	**23**	**92**	25	23	92
ONGs	----------			75	50	66	25	20	80
	Total			1000	513	51	1000	633	63

Midwives: Number of traditional midwives trained in prenatal and obstetric care.

Department and Municipal level	IMCI			IMCI-C			Reproductive Health		
	Objective	achieved	%	Objective	achieved	%	Objective	achieved	%
MOH San Marcos	----------			129	104	81	411	268	58%
MOH Quetzaltenango	----------			----------			223	155	69%
MOH Suchitepéquez	----------			----------			148	124	84%
MOH Retalhuleu	----------			----------			18	14	78%
MOH Sololá	----------			----------			-	-	-
Social Security	----------			----------			-	-	-
IGSS									
Total	----------			129	104	81	800	531	66%

I. B. What factors contributed to these successes?

The Factors which have contributed to these successes are:

- The respect which Project HOPE has demonstrated for member institutions, the recognition of the preeminence over the health region which the Ministry of Health holds, and the focus which the program has had to be able to contribute to making operational

- National policies and strategies which have been implemented to improve the health situation of the Guatemalan population.

- Approaching all social actors who participate in the program, maintaining two way communications at the national, departmental, municipal and local levels.

- The timely response which Project HOPE always has for the technical and financial support needs of the members.

- The quality of the technical assistance which is provided.

- The quality of the human resources which Project HOPE has, the majority of whom are very committed to their work and manage to motivate the involvement of the personnel of the member agencies.

- The participation of the members in activities of evaluation of the program such as the mid-term evaluation in which personnel of the social agencies form evaluation teams to support the external evaluator. This has strengthened them technically and also they have been able to identify for themselves what are the strengths and weaknesses of the program.

- HOPE has carried out planning and evaluation meetings annually and has taken advantage of these so that the members can give their opinions on how to improve some aspects and whether they consider a reorientation necessary.

  The following table lists the objectives of the program and indicates with yes or no whether progress toward the objectives is being realized and comments on each one of the objectives.

Objectives of DIP	Progress	Observations
1. Objectives of Building Capacity: Increase RH and impact assessment expertise of Project HOPE Guatemala	Yes	• HOPE has achieved the formation of highly competent teams in child health, reproductive health and research. Formation of human resources has emphasized adult education, planning and monitoring and evaluation. • HOPE has received the technical assistance of staff from HOPE Headquarters and the involvement of external experts, as well as exchange of experiences with other programs of CS which HOPE is developing in other countries. • HOPE Center has begun the use of internet-based technologies, such as electronic sessions by which we can hold regional meetings with presentations, conferences and discussions of technical matters, strategies and research methods, which has permitted the staff of HOPE Guatemala to learn and share.
2. MOH and IGSS assess and improve backstopping capacity	Yes	• HOPE, together with the Coordinator of the National Program for Migrants has held quarterly meetings at the national and departmental levels with the members to strengthen the planning and follow-up of care activities for residents and migrants and to evaluate the activities of the operational plans which are developed annually. • At the local level HOPE gives technical assistance to the health services to implement national health strategies, to monitor the trainings and of the performance of the institution's personnel and volunteers as well as to improve education at the community level.
3. Health area and municipal health councils allocate human and material resources to plantation	Yes	• HOPE is helping the Health Areas to strengthen the Departmental and Municipal Boards of Health to achieve the mobilization of the resources of

resident and migrant health.		those institutions that make up this organization, for health campaigns which are held on the plantations and in nearby communities. • During the harvest season of 2003, 96 health campaigns were held on the farms and communities by Health personnel and the IGSS, in the afternoons and evenings, adapted to the needs of the migrants. • 183 rural promoters from the Basic Health Units have been trained in the AINM-C strategy to give direct care to children and education to the others on the prevention of illnesses and the timely search for health services during the whole year.
4. The MOH/IGSS will maintain and support a core of Children's Health, Reproductive Health, and QI Master Trainers for health providers and for community agents at the Health Area level.	Yes	• HOPE has supported the core of trainers with technical content, teaching methods, supervision and tools for monitoring the quality of case handling and research methodologies, and to provide feedback to partner institutions. • The consolidation of 5 cores of master trainers at the departmental level and 30 teams of facilitators at the municipal level for the strategies of AIEPI, AINM-C and Essential Maternal-Neonatal Care (AMNE); • 80% of the staff of member institutions have been trained in handling protocols education and counseling in AIEPI, AINM-C, and AMNE. • The 29 health services in the program carry out monthly review sessions with promoters and midwives to provide follow-up to the trainings which they carried out with volunteer personnel.
5. Partner agencies have increased capacity to collect and use qualitative and quantitative data for management and decision making, including data generated and submitted by the community agents.	Yes	• Technical teams from the 3 Health Areas and the IGSS are trained in the design, implementation and interpretation of rapid quantitative and qualitative evaluations. • Staff at the national, departmental and local level of partner institutions have participated in the evaluations of the

		program such as EMT, the KPC survey, the LQAS rounds, the Focus Group research to develop the reminder materials for mothers on the danger signs of children under 5 years. 86% (13) of the 15 districts who have Basic Health Posts on the farms and communities include information generated by the promoters and midwives in their information systems; 118 (87.4%) of the promoters report monthly.
6. Formal health services (MSP, IGSS, and NGO's), will demonstrate increased commitment to quality health care and improved community participation.	Yes	• 80% of the health establishments use cards, laminated sheets and algorithms corresponding to the AIEPI, AINM-C and AMNE strategies. • The Master Nuclei of the Health Areas have held Performance Monitoring of the personnel in the AIEPI strategy in 50% of their health establishments to identify weaknesses, and afterwards programmed strengthening of the weak aspects of their practices and trainings for newly entering personnel. In the 4th year of the program they will carry out monitoring on the rest of the establishments. • Jointly with the Maternal-Neonatal Program of JHPIEGO and the national level of the MSP, carried out a base line questionnaire of AMNE which identified some weaknesses in the delivery of services for maternal and neonatal health, afterwards they carried out interventions to improve and then a new evaluation, and have certified 3 of the evaluated establishments which belong to the intervention are of the program as having achieved the maximum number of points and complying with all established requirements.
7. Participating plantations improve the health infrastructure.	Yes	HOPE promotes the increase in coordination of the MSP and the IGSS with the owners and administrators of the plantations. One care clinic for resident and migrant populations was

		implemented in a place that was loaned by an owner very close to a plantation, and this was achieved with the support of the ACAT coffee growers association, HOPE and Funrural Anacafe. The clinic provides attention 3 days of the week, the costs is minimal, about $1, HOPE supports it with a small pharmacy in coordination with the NGO ADISS, which is run as a revolving fund. 38.5% of the plantations have improved the health conditions as regards latrines, potable water and dormitories for the migrants.
8. Increase availability of basic Reproductive and Child Health messages in Spanish and common Mayan languages on the radio stations in the Boca Costa and the communities of origin.	Yes	• 15 radio stations in the Boca Costa and the highlands transmit messages daily on child and reproductive health in Spanish and Mayan.
	No	• In agreement with the LQAS report of September, 30% of the resident mothers can remember at least two child and reproductive health messages (the goal is 60%). During the 4^{h} year we will negotiate with other radio stations and will use other strategies to increase the percentage.
9. Community Agents: Common childhood illnesses are managed according to the IMCI protocols at the basic health units on the plantations.	Yes	86% of the health districts which have Basic Health Units carry out monitoring of the performance of the health promoter in the strategy of AIEPI-AINM-C 118 health promoters (87.4%) report their activities monthly to the health center.
	No	In monitoring of job performance which was carried out recently only 52.4% of the promoters classified and treated cases appropriately, and adequate advice was given in 43%. This aspect is being strengthened with supervision and tutorial help to achieve the goal of 80%. This objective has not been adequately achieved due to constant staff rotation caused by workers leaving the plantations due to the low price of coffee.
10. TBAs conduct cleaner	Yes	• According to information collected by

and safer births.		the health service, approximately 50% of midwives are reported as using birth equipment and cutting the umbilical cord with boiled scissors. • 29 health posts hold monthly follow-up meetings with trained midwives. • 550 midwives received refresher training in caring for a clean and safe birth. • 103 of 200 newly scheduled midwives have been trained.
11. Promoters/volunteers are more effective in their community mobilization/health education efforts.	Yes	• HOPE is supporting the core of master trainers for training and supervision of promoters for child and reproductive health and adult education methodology. • 29 health posts hold monthly review meetings for promoters. • 85% of 135 people interviewed in the recent Basic Health Post study stated that they give educational chats to groups of mothers once or twice a month and also that they take advantage of the daily consultations for advice.
12. Community based distribution agents promote FP and condoms	Yes	100 community agents who distribute family planning methods have been trained to make FP services more accessible in the communities and plantations, as well as referral to health services. One health district reported an increase in the rate of use of FP methods from 23% to 44% for the advice and referrals which the CBDA's have.
Knowledge and practices will be improved at the household level.	Yes	See the table of household level indicators in Section IV, insert B.
14. Resident and migrant demand for health services increases	Yes	In accordance with information generated by the Basic Health Units, demand has increased and now attention is given throughout the year and not only at harvest time. In Feb. 2005 an Addendum will be presented with specific information on services provided by the health units for residents and migrants. Some districts have informed us that the health units are now producing as many consultations as the Health Posts.

15. HOPE capacity increased for CS/RH programming.	Yes	All activities scheduled for this objective have been completed: Baseline, DIP and annual reports submitted, the Mid-Term Evaluation carried out, and the evaluation of organizational capacity performed.
16. Health areas/municipal health councils have strengthened service delivery policies for migrants.	Yes	There exists a national policy which guarantees care to migrants; this is operationalized at the departmental and municipal level. HOPE has established close relations with the national level program coordinator, who holds quarterly meetings with technical teams in the Health Areas to plan and evaluate activities.
17. Revolving drug funds operating in low-access plantations and municipalities.	Yes	We have not been able to make much progress putting in place new medicine stores with revolving funds via the coordination of the national NGO ADISS, since the National Program for Access to Medicines (PROAM) has had problems supplying the already established stores and has not been able to widen its field of action. Only 8 stores at the municipal level and 9 rural ** have been established.
18. Health areas/municipalities/IGSS allocate sufficient resources to training, supervision and follow-up of health facility staff and community agents.	Yes	• The consolidation of 5 core master trainers at the departmental level and 30 teams of facilitators at the municipal level in strategies of AIEPI, AIN-C and AMNE; • 80% of the member groups' staff are trained in handling protocols, education and counseling in AIEPI, AINM-C, and AMNE; • 29 health services that are involved in the program carry out monthly review sessions with promoters and midwives to provide follow-up to the training which they have carried out with the volunteer personnel.
19. Data inform decision – making at all levels.	No	• HOPE has supported the health districts in strengthening their information system via tools to gather, present and analyze the data, but involvement of the partners in giving up time for the analysis, which could be used to make decisions, is lacking. The 4th year of the program will focus on strengthening the situational room in the health

		districts.
20. Plantation HU data integrated into and used in MOH HIS	Yes	• 13 of 15 health districts use data created by the promoters on the plantations in their information system. • 85% of the promoters send their data to the health service to which they belong monthly.
	No	• The health services do not use the data to make decisions since they say they lack time to analyze it monthly. The emphasis of the program in the 4h year will be to strengthen the capacity for analysis at the local level via supervision and direct support to each of the health establishments.
21. HU promoter supervison/refresher meetings conducted monthly at closest MOH facility.	Yes	• Staff of the MOH and IGSS have made at least 1 visit of supervision to 60% of the health units quarterly. • HOPE has worked to transfer adult education methodology to facilitators at the departmental and municipal levels, has supported them in planning the sessions using animation techniques, motivation, appropriation, transfer and evaluation of educational activities for volunteer personnel. • 29 of the intervention districts carry out refresher meetings monthly for volunteer personnel which are run by health personal with the support of HOPE staff.
22. MOH health campaigns and preventive activities on plantations during harvest.	Yes	• 64% (96) of the plantations that receive migrants had a health campaign by the MOH and the IGSS, with the help of HOPE, during the harvest of 2003. They held 2,835 consultations, 138 prenatal visits, 15 postpartum visits, 150 iron and folic acid treatments for pregnant women, 250 doses of Tetanus Toxoid/Diphtheria vaccine to women of fertile age and 96 pregnancies as well as 1048 doses of Vitamin A to children and nursing mothers, educational chats and dormitory inspections.
23. Plantation HUs have	Yes	• HOPE has provided the timely resupply

continuous supply of essential drugs and supplies		of medicines to the basic health posts. • The Health Districts are more committed to the re-supply of medicines, 45% of the Basic Health Posts receive monthly and quarterly re-supply in accordance with the last study of the Basic Health Units carried out.
24. Plantation owners and municipal directors meet at least quarterly to address plantation health issues.	No	• 4 networks of owners and administrators of plantations have been formed of the 8 planned. • Due to the problems created by the low coffee prices, the owners and administrators of plantations have not been attending the meetings scheduled by the districts, as they had done earlier. • The directors of the districts, with support from HOPE, have changed the strategy, and now they carry out joint visits to the plantations to maintain the support of the owners and administrators, and this is having good results and is improving coordination by both sides.
25. Plantations include cost of maintaining promoter and HU in their annual budgets.	No	• Only 8.1% of the plantations pay the promoter a salary for exclusive work in the Basic Health Units. • 16.3% of the plantations pay the promoter for the work, and they also do other functions on the plantation. • 11.9% of the plantations contract health staff to help the promoter during the harvest season. • 41.5% of the plantations provide incentives to the promoter (extra day's pay for attending trainings, travel allowance.) • 17.8% buy medicine • 39.3% provide maintenance for the health units. • 37% provide vehicles for health fairs or emergencies.
26. Increase demand for Basic Health Unit and health facility services	Yes	• 89.5% of the users of the Basic Health Units are satisfied with the care received.

		• 96.7% of the users trust the treatment that the promoter arranges. • 86.4% of the users are in agreement with the schedule of coverage available.
27. Implement 10 new Basic Health Units on plantations	No	• This objective has not been achieved due to the critical economic situation which has been caused by the low price of coffee. Many plantations were sold and those in charge of the health units were let go. It has been a lot of work to keep the 155 health units active. In the original program they set up 150 health units, of which only 87 are still active and in the extension we have achieved the creation of 67 more units to make a total of 155 health units which are functioning on farms and in the communities of the resident population.
28. Health councils at the department and municipality levels, promoting health services for migrants.	Yes	• HOPE participates in the Governing Board and commissions of the Departmental councils at the level of the Health Areas, attending monthly meetings, taking advantage of the opportunities to strengthen education at the community level, mobilization of resources for the care of migrants and to consolidate the Master Core groups in the Health Areas.

I. C. Description of the Exit Phase of the Program

Project HOPE is strengthening the ability of its partners to achieve institutionalization of program activities. A graduation strategy has been planned for the health establishments, cores of master trainers, the member institutions and for the health units located on plantations and nearby communities. Graduation is considered a very positive event, showing that a particular unit has achieved the ability to run itself successfully. HOPE has developed along with its partners a monitoring tool for the units which have graduated. With this intervention, HOPE transfers the responsibility of monitoring to the MOH and other partners. In the first quarter of the fourth year, the graduation criteria will be applied to all levels considered part of the sustainability of the program.

Actions Taken by the Program:

- We are strengthening the Master Cores of he Health Areas and the Social Security to assign resources for training, supervision and follow-up of institutional personnel and of community agents.

- We are accompanying the Master Cores of trainers to monitor performance and strengthening weak areas in applying the strategies of maternal child health, taking into account information to apply the graduation criteria of the health posts.

- HOPE staff ensures that the data generated by the health units are integrated into the information system of the MOH, which is then analyzed and used to make decisions.

- HOPE actively participates in the Departmental Health Boards, ensuring the formation and strengthening of municipal health boards to achieve the best use of resources for maternal child health activities.

- We are supporting health services for the training and follow up of the promoters and midwives that provide health education, basic prevention and curative services for migrant and resident children and mothers. We are strengthening the self-guidance capacity in the health services to look for other sources of financing to support these activities.

- We have helped the health services include in their annual operational budget funds for the activities which this program is currently supporting.

- The health services are responding positively to their commitment to give medications to the basic health units, and now request medications for the basic health units routinely, and help the promoters fill out the order form.

- The directors of the health establishments are making visits to the owners and administrators of the plantations to motivate their participation and help for program activities.

- They are facilitating the carrying out of integrated health campaigns during the coffee harvest season to care for migrants and residents of the coffee plantations with the participation of owners and administrators of the farms.

- They have carried out a study on the Health Units to obtain information which will allow them to apply the graduation criteria to their plantations.

- Jointly with the social agencies they are developing incentives and prizes for the owners/administrators of the plantations to recognize their participation in program activities.

- They are constantly motivating personnel of the partner institutions to become involved in supervision and follow-up to health activities at the community and plantation level.

II. Factors Which Have Blocked Progress Toward Achieving the Objectives

What factors have impeded progress toward achievement of the overall goals and objectives and what actions are being taken by the program to overcome these constraints?

The negative factors which this program has had to face are always along the same lines as what was presented in the first annual report and in the mid-term evaluation and they are the following:

- Implementation of 250 basic health units which were planned in the DIP; because of the difficult economic situation which the country has been facing since the year 2001 with regards to the fall in coffee prices, many plantations were sold, and people were let go, amongst them personnel who were in charge of providing care in the units, therefore in the first annual report it was reported that by the end of the project only 200 units would be set up.

- Due to the change in authority of the government which occurred at the beginning of 2004, involvement of the municipalities to support the training of promoters and midwives has not been achieved, neither have they obtained additional support for staff during the harvest season and other support to sustain project activities.

- It has been difficult for the project to receive access to the reports of the activities of the health posts on the plantations and the coverage of care to the migrant population, the information collected by the MOH and the IGSS during the medical days on the plantations during the coffee harvest, owing to rotation of staff in the health units, in the institutional services, or owing also to the lack of care in some of the services who have to collect information which is generated at the community level.

- Another aspect which has been difficult is preventive education at the household level, HOPE is working to strengthen the institutional capacity of the members, but does not have responsibility to execute direct action in the community. Nonetheless, we have

supported the members in the delivery of care and education, so the results of the program depends on how the members are involved and respond to the planned commitments.

Actions taken to meet the challenges:

- HOPE is helping the members implement Basic Health Units in the communities of residents and is strengthening the capacity of those which are still active so that a good percentage of them will remain sustainable at the end of the program.

- We are looking for support of the committees of community improvement to back up the volunteer promoters who have set up Basic Health Units in their homes.

- We are helping the health services identify new sources of funding for supplying medications and to continue training activities for volunteer personnel.

- Workshops have been held with the participation of national, departmental and municipal authorities of the institutional partners to offer tools for gathering, tabulating and presenting data to motivate the use of the tools to convert the data to help in decision making and thus resolve the problems of health information.

- To deal with the problem of preventive education, an aggressive IEC plan has been implemented the Health Areas are motivating personnel to carry out educational activities at the community level through promoters, midwives and community leaders, they are also looking for help from other organizations which work in the intervention area, taking advantage of the existence of departmental and municipal health boards. This plan also calls for monitoring 12 indicators through LQAS rounds every 6 months, the first session has been held and its results are shown in Section IV, part B of this report.

- The Guatemalan Social Security Institute has an educator in each municipality in the intervention areas and they are coordinating staff of the health centers and posts to carry out educational activities focusing on the indicators which are being monitored.

III. In What Areas Does the Project Require Technical Assistance?

The program has received high quality technical assistance; nonetheless we need help from the CSTS project to detail the final steps to achieve sustainability, transfer to partners, and provide technical assistance in the "Behave" framework, monitor and evaluate program.

IV. A. Description of Some Changes Resulting From the midterm evaluation

- Some of the changes in relation to the DIP and the Midterm Evaluation refer to the number of health units which should be implemented, as we have explained it has

been difficult to maintain, recover or create new posts and so we are far from achieving the goal of having 200 functioning units located on coffee plantations. The factors influencing this situation are completely external and out of the control of the program. The change therefore is in the number and location of the units. Currently the units are being implemented in communities of resident populations. We have concentrated on strengthening the 155 units which we currently have and from which we have chosen some which have the potential for sustainability.

- Another change in regards to the geographic area of intervention is that it was not possible to work with the municipality of Santiago Atitlán de Sololá which had been proposed as a municipality in the program, since it has a Health Center and one health post, with an organization that covers various communities in the "extension of coverage" and several other organizations which are running health projects. The Director of the Health Center thanked us for the help which was offered by the program and explained that it was better that it be used in other communities that did not have other support. This community was taken into account in the proposal because it received a large number of migrants in previous years, but the situation has changed and the plantations have given up the cultivation of coffee for other more profitable crops.

B. How is Data Being Used for Monitoring?

HOPE has implemented a quarterly monitoring system which uses data from the monthly reports which are provided by the technical and field personnel of the program, and which counts on various tools for collecting and tabulating and provides data which are converted into indicators for each quarter. We have a data base which includes the plan for all four years of the program, year by year.

Review of Benchmark Progress:

TABLE 2: Project Benchmarks

Indicator	**Goal, LOP**	**Achieved**	**% Achieved**
Number of health workers trained (child health and nutrition, community IMCI, AIN-C, reproductive, maternal health)	450	360	80
TBAs trained in child health, maternal and reproductive health Promoters trained in child health, maternal and reproductive health CBDAs trained in child spacing	1000 200 100	531 192	66 96
Number of trainers active in 29 municipalities	132	132	100
Number of quarterly meetings held with partners to analyze data for decision-making using "sala situacional" , LQAS information to adjust project work plan	12	9	100
Number of Coffee Growers Networks involved in health initiatives	8	2	33
Number of planning meetings with coffee estate administrators	96	15	20
Number of Basic Health Units (HUs) that are active, provide services at convenient hour: a) HUs inside coffee estates, b) HUs in communities close to coffee estates	250	150	63
Number of visits to Health Units per year by children and mothers			

Indicator	Goal, LOP	Achieved	% Achieved
during a) Coffee harvest season (includes migrants) b) Remaining of the year (only resident population)	 12000 TBD	 5,926 3,957	 50% 66%
Number of outreach campaigns including one or more of the following activities: growth monitoring and promotion, MN supplementation, immunization, deworming, pre-natal care, treatment of acute conditions in coffee plantations	600	302	67
HUs with adequate inventories of essential supplies (%, based in supervisions)	80%	60	40
% of resident mothers satisfied with the services provided by HUs [exit interviews]	70%	330	89.5
% of migrant mothers satisfied with the services provided by HUs [exit interviews]	70%	52	84.2
Number of supervisions made by MOH staff to HU based providers Percent of monthly meetings at health facilities HU providers attend	6,000 80%	2000	55
% of institutional providers performing accordance with IMCI norm[critical areas] % of community-based providers performing accordance with IMCI norm [same]	60% 70%	250 35	55 30
Number of municipalities conducting FHA	TBD		
Number of radio stations broadcasting messages in Mayan languages	15	15	100
Number of resident children under 2y participating in GMP sessions in selected highland/ Boca Costa communities/plantations where AIN is being implemented % of children gaining weight according to the norm (mini-study)	TBD 70%	Study has not been carried out yet.	
Number of mothers receiving health education in coffee plantations	200	75	50
% of TBAs using clean birth kits, (mini-study)	75	450	60
Number of coffee estates with emergency transportation	250	50	20
Number of coffee estates providing transportation for health campaigns	250	50	20
LQAS monitoring rounds conducted	2/year	1	50
Number of municipalities where HOPE/partners overlap CS interventions with related activities: sanitation, micro credit, food security, low-cost drugs, other	15	5	40
Number of plantations allocating financial resources to HUs during that year	150	20	20
New funding sources identified for project activities	3	0	0

During the third year of the program, emphasis was put on strengthening knowledge and ability of the partners in modern techniques of supervision and monitoring. In April 2004, a workshop was held to apply the Lot Quality Assurance Sampling methodology (LQAS), and it was taught by the epidemiologists from the 4 Health Areas. In this workshop they also included the use of PDAs to gather data and as support for the immediate analysis of information through special software. This methodology was proposed for monitoring maternal child health indicators at the community level and also as a tool to monitor programs and the quality of services the health establishment are offering. This was accepted by the assistants and by the departmental health authorities for its feasibility, low cost and staff can carry out surveys as part of their regular work.

LQAS Survey:

In the month of September we carried out the first round of LQAS in the three intervention areas of the program, with the participation of health personnel to provide follow up to the 12 indicators of maternal and child health which were reported as being very low during the midterm evaluation of the program.

The general objective of this study was monitoring the impact achieved of the health interventions carried out by the Child Survival program and to determine how much they had advanced.

The sample consisted of 175 mothers of children under 2 years old who lived in communities where at least one health intervention had been carried out from amongst the intervention areas of the Child Survival program.

To calculate the sample they used the LQAS methodology, doing 25 interviews in each supervision area. There were seven supervision areas that were considered for this study: two in Quetzaltenango, two in Suchitepéquez and three in San Marcos.

Results

A. Comparison of the study made of the average term in the year 2003 and a monitoring study in 2004

1. Percentage of children from 12 to 23 months that were completely immunized

It was observed for this indicator that in the 2003 study 21.8% was reached in comparison to the 82.6% that was reached in the 2004 study; these results show a difference between both studies of 60.8%. According to results from the National Survey of Maternal and Child Health (ENSMI), in the year 2002, 62.5% of children 12 to 23 months were completely immunized, in a comparison between these results and those reached in the monitoring study in 2004, there is a positive difference of 20.1% in the area of Child Survival program intervention. The difference between both studies can be attributed to the last survey's use of information triangulation, in that the surveyor asked for the vaccine card, waited a necessary amount of time for the mother to find the document, when the mother did not give it but she assured the surveyor that the child had all of his vaccinations the surveyor would look in the registries of the vaccination service to verify.

2. Percentage of children from 6 to 23 months that had received doses of Vitamin A in the 6 months prior to the interview

The information regarding vitamin A supplementation was verified through the infant ID cards and the General Information System of the Ministry of Health. The obtained results regarding the percentage of children from 6 to 23 months that had received doses of vitamin A, in the 6 months prior to the interview, in 2003 was 13.6% and for 2004 it rose to 30.0%. The difference between both studies was a 16.4% positive difference for the last study relating to 3 of each 10 children that received supplements.

3. Percentage of mothers that exclusively breastfed for six months after giving birth

The study made in 2003 showed that 65.3% of mothers exclusively breastfed for six months after giving birth and that number rose in 2004 to 70.7%, which made a difference of 5.4% between the two studies. To determine this percentage a record was made of all of the food consumed within a 24 hour period by each child and then only the children that had been exclusively breastfed were chosen.

4. Percentage of mothers that offer the same amount or more of breast milk, liquids and/or food during a diuretic episode

The percentage of mothers that offered the same amount or more of breast milk, liquids and/or food during a diuretic episode to children younger than 2 years old for the year 2003 was 41.7 and for 2004 it was 23.5. The difference between both studies is 18.2% the percentage being greater in the previous study. Different analyses can be made by separating the children into

groups; the percentage of children that received the same amount or more of breast milk during a diuretic episode was 68.6%, the percent of children that received the same amount or more of liquids was 74.5% and mothers that offered the same amount or more of food was 39.2%, these three results are high but by forming the indicator with the three variables lower results are observed. The percentage of children of 0 to 23 months that received oral rehydration salts and/or homemade liquids recommended for diarrhea in 2004 was 52.9% and in 2003 was 7.1%

5. Percentage of mothers that can mention at least two child or reproductive health messages that they had heard on the radio

The percentage of mothers that can mention at least two child or reproductive health messages that they had heard on the radio in 2003 was 0.0% and 30.9% in 2004. The messages that the mothers indicated that they had heard were: family planning, vaccination, child nourishment, exclusive breast feeding, hygiene relating to food preparation, etc.

6. Percentage of mothers that received at least two doses of Tetanus Toxoid (TT) before the birth of their youngest child, less than 24 months old

According to the results the percentage of mothers that received at least two doses of Tetanus Toxoid (TT) in their last pregnancy (youngest child) for 2003 was 10.0% and for 2004 it was 17.7%. There was a favorable difference of 7.7% in the last study, for this indicator mothers were selected that had presented their maternal ID and that had received doses of Tetanus Toxoid (TT). To assure attainment of the information, the interviewed mothers that were solicited had shown their maternal ID card for their last pregnancy (child younger than 2 years old), that way the interviewer could assure that the information was being collected. The total percentage of mothers that received at least two doses of Tetanus Toxoid or TT before the birth of their youngest child, younger than 24 months old, that were asked about vaccines and or that presented their maternal ID card was 24.6%. Regarding the vaccination TT, the women who were immunized in their next to last pregnancy were no longer considered for the vaccination, as it provides biological protection for 10 years.

7. Percentage of mothers that received at least 3 prenatal visits in their last pregnancy

The study completed in 2003 found that the percentage of mothers that had received at least three prenatal visits throughout their last pregnancy was 6.4% and for 2004 the percentage was 36.6 with a difference of 30.2% between both studies. The mothers that were interviewed indicated that they had attended prenatal counseling because they had heard that was good to go in order to learn how their children were going to be born. The obtained results for the percentage of mothers that had at least one prenatal visit in their last pregnancy, as demonstrated on their maternal ID cards, for 2004 was 90.7% and the percentage of mothers that received at least one prenatal visit of all of the mothers interviewed (175) was 50.3%.

8. Percentage of mothers that reported at least two danger signs during their pregnancy and the post partum period

The results obtained from the study in 2003 indicated that the percentage of mothers that reported at least two danger signs during their pregnancy and the post partum period was 8.4 and for the year 2004 it was 66.9, the different between the two studies was 58.5% positive for the last study. This indicator was made with the total number of mothers that indicated that they recognized at least one danger sign during both periods, but when it was formed with the total number of mothers that were interviewed (175) 39.4% was obtained. By doing this indicator separately (pregnancy, partum and post partum) the following results were obtained: the percentage for the period during pregnancy was 51.4%, during partum was 47.4% and for postpartum it was 40.5%, these indicators were constructed with all of the interviewed mothers (175) throughout 2004. The health service personnel that participated in the collection of this data knew the mothers' situations during the interviews regarding this subject matter and were compelled to better the interventions that were made, review what they had talked to the mothers about regarding danger signs and reinforce points where the results of the study were low.

9. Percentage of mothers that had at least one postnatal visit

For 2003 the percentage of women that reported at least one postnatal visit was observed to be 3.9% and for 2004 it was 20%, the difference between both studies is 16.1% positive for the year 2004. Even though the difference is high between both studies the importance of a postnatal consultation needs to be reinforced so that mothers will attend. The mothers indicated that they are going to a health service after they give birth, for medical attention for their newborn, but in many cases they do not recognize how important a postnatal consultation is for them.

10. Percentage of children from 12 to 23 months that receive the measles vaccine

The results obtained from a study regarding the percentage of children from 12 to 23 months that received the measles vaccine was 21.8% in 2003 and in 2004 it was 82.6%, which makes a difference of 60.8% between both, the difference is positive for the year 2004. Like the indicator for complete immunization, for this indicator interviewed mothers were solicited that showed the infant vaccination card so that the information could be recorded on the data collation ticket, in cases where the document was not available at the time of the interview the Managerial Information System of the Ministry of Health in health services was consulted. In cases where health service personnel assisted with the collection of data, this information could be taken at the time of the interview.

11. Percentage of children from 6 to 9 months that received breast milk and complementary nourishment in the last 24 hours

The results of studies from a program monitoring the percentage of children ages 6 to 9 months who received breast milk and complementary nourishment in the last 24 hours for the year 2003 was 40.0% and for 2004 it was 84.6% there was a difference between both studies of 44.6%. To

obtain this information a record was made of all alimentation within 24 hours which made it possible to determine what the child had eaten and drank the day before.

12. Percentage of children from 0 to 23 months of age whose births were attended by enabled health personnel

In the study made in 2003 it was determined that the percentage of children from 0 to 23 months of age whose births were attended by enabled health personnel (doctors, nurses and nurse assistants) were 37.6% and for the year 2004 49.1%, the difference was 11.5%, positive for the last study. When considering in this indicator attention during childbirth from midwives and the other health promoters including doctors, nurses and nurse assistants the results for 2003 were 99.6% and 96.0% for 2004. According to the study 50.9% of the childbirths were attended at the community level.

According to results from monitoring the 12 indicators that were studied a highly significant difference was observed between the study from 2003 and the 2004 study. The results of which reflect the results of the maternal and child health interventions that had been made during this year at a community level by the Ministry of Health personnel and other instances of coverage extension with the support of the Child Survival program. Inter-institutional coordination has been a determining factor in reaching these results, for this reason the implementation, execution and monitoring of the maternal and child health strategies needs to be fortified.

TABLE No. 3: KEY INDICATORS

INDICATORS	*OBJECTIVES*	YEAR 2003					YEAR 2004					DIFFERENCE BETWEEN YEARS	P VALUE
		YES	NO	n	%	CI	YES	NO	n	%	CI		
1. Percentage of children from 12 to 23 months that are completely immunized	70%	29	104	133	21.8	(14.9 – 29.0)	71	15	86	82.6	(82.4 – 83.6)	* + 60.8	0.000
2. Percentage of children from 6 to 23 months that had received doses of vitamin A in the 6 months prior to KPC	50%	29	184	213	13.6	(9.3 - 18.6)	42	98	140	30.0	(29.4 – 30.6)	* + 16.4	0.000
3. Percentage of mothers that gave breast milk exclusively during the first six months after giving birth	70%	64	34	98	65.3	(55.6 - 74.4)	29	12	41	70.7	(67.9 - 72.0)	* + 5.4	0.975
4. Percentage of mothers that offered the same amount or more of breast milk, liquids and/or other nutrients during a diuretic episode	It is increased to 60% in relation to the base line	35	49	84	41.7	(31.4 - 52.6)	12	39	51	23.5	(21.6 - 24.4)	NS - 18.2	0.100
5. Percentage of mothers that can mention at least two child or reproductive health messages that they heard on the radio	60%	0	311	311	0.0	(0.0 - 0.0)	54	121	175	30.9	(29.5 - 30.5)	* + 30.9	0.000
6. Percentage of mothers that received at least two doses of Tetanus Toxoid before the birth of their last child, younger than 24 months	60%	31	280	311	10.0	(5.8 - 12.18)	31	144	175	17.7	(16.7 - 17.3)	* + 7.7	0.055
7. Percentage of mothers that received at least 3 prenatal visits during their last pregnancy	50%	20	291	311	6.4	(3.4 - 8.6)	64	111	175	36.6	(35.5 - 36.5)	* + 30.2	0.000
8. Percentage of mothers that reported at least two danger signs during their pregnancy and post partum period	50%	13	142	155	8.4	(3.7 - 12.3)	69	34	103	66.9	(66.2 - 67.8)	* + 58.5	0.000
9. Percentage of mothers that had at least one postnatal visit	40%	12	299	311	3.9	(31.6 - 72.4)	35	140	175	20.0	(19.6 - 20.4)	* + 16.1	0.000
10. Percentage of children from 12 to 23 months who received the measles vaccine		29	104	133	21.8	(14.9 - 29.0)	71	15	86	82.6	(82.4 - 83.6)	* + 60.8	0.000
11. Percentage of children from 6 to 9 months who received breast milk and complementary food within the last 24 hours		16	24	40	40.0	(24.8 - 55.2)	33	6	39	84.6	(82.6 - 85.4)	* + 44.6	0.000
12. Percentage of children from 0 to 23 months whose births were attended by trained health personnel		117	194	311	37.6	(37.7 - 38.3)	86	89	175	49.1	(48.4 - 49.6)	* + 11.5	0.005

NS = Not Significant *** = Significant**

V. Was any information required by the Midterm Evaluation?

The information for the midterm evaluation includes specific recommendations for each one of the evaluated areas.

- **Recommendations for training activities:**

It recommends increasing observation, supervision and feedback to the master trainers which should be implemented as soon as possible. The plan of action developed on the basis of these recommendations raises the consolidation objective of the training process through the strategy of continued fortification of facilitators at the department and municipal level. This is being obtained and the emphasis has already been on this fortification like it was described in the part of the institutional fortification, as HOPE is accompanying core facilitators in the replication of training at different cascading levels, in the monitoring and in the supervision of training.

- **Recommendations for the basic health units:**

The project should focus its efforts on the health units that are actually active and establish the quality of those that have a good opportunity for sustainability when the project is over. The project should document and share strategies and lessons learned at the national and international level. To obtain this recommendation an investigation has been conducted of the actual status of the units to establish which ones have the possibility of sustainability, and evaluate the aspects related the performance of the promoter who cares for the unit, the infrastructure of the units, the support that they receive from the owners, property administrators and from the residential community committees where these units function. There is a strong emphasis on working to motivate health services to fulfill their commitment to regularly and opportunely supply medications to the units. It is also reinforcing the supervision of units by medical personnel and nurses in order to support the promoters in case management performance and improve the quality of care that they offer. It has not been possible to fulfill the recommendation of exploring options to equip the basic health units with Salter type scales to implement the AINM-C strategy since the backing of partner institutions was not obtained and the program does not posses sufficient funds to purchase this equipment.
There is also a strong emphasis on using the information the promoters generate to make the same analysis jointly with the promoters, health personnel and the personnel of HOPE.

- **Recommendations for education in health prevention:**

Consolidate and assure the complete distribution of the IEC project materials to partners and community volunteers. This would be based on an investigation of IEC material distribution. The project must increase its efforts to strengthen the abilities of the advisory promoters to promote, through the IEC, the negotiation of behavior changes. Other community mobilization techniques, such as the formation of support groups for women who breastfeed, should be considered. At the moment, the project is compiling information regarding the

handling of material that has already been distributed. An IEC plan was implemented with personnel from the Areas of Health that came up with a technique to reach the community, through groups that midwives are forming with their patients to teach them about danger signs and breastfeeding. The promoters are forming emergency committees in their communities and are making educational activities in their town. They have been holding workshops with partners to increase their IEC strategic abilities.

- **Recommendations for Inter-institutional Coordination**

In the mid-term evaluation referring to coordination with partners reported one of the programs strongest strategies, nevertheless some suggestions for continuous improvement remain to be written. One suggestion is to consolidate the coordination with a greater variety of agents, along with project partners, such as NGOs, religious groups and government institutions with health related activities, to be able to use these resources to reach the maximum coverage for the training activities and the new approaches of the MOH. In reference to this suggestion, the project has been working hard with the areas of health to strengthen the health council departments that includes several indicated actors, providing the confirmation of the municipal health council through Joint Directives of the Counseling Departments of health and searching for approaches with other groups. It is trying to have the districts of health invite the municipal health authorities so that they participate in relation to health. They are also coordinating activities at a local level with Social Security educators.

VI. Flexible Funds

It does not apply.

VII. Description of the Program Management System

A. Financial Handling System:

The administrative management of Project HOPE Guatemala is responsible for monitoring expenses vs. budget at a local level. They create and send monthly financial reports to the Central Offices of Project HOPE, based on the requested corresponding reimbursements. During the monthly process of sending reports, there is continual communication between the personnel at the Central Office and the personnel in Guatemala, which allows for suitable feedback regarding financial matters. Based on the data from the financial reports, the Assistant Director is informed of the actual expenses during the corresponding period, in relation to the expenses which effect the field program, so that the technical part of the program has updated information when making decisions.

There are paper copies of all of the local expenses, which are filed and safeguarded in the Guatemala office.

B. Human Resources

It is included, like annexed, the organizational chart of the program, in which 26 people work, the majority of them work full-time on project activities. The National Director meets monthly with the Assistant Director and program managers, to pursue and discuss the achievements of the project, results, weaknesses, limitations, analysis and solutions to problems in order to make corresponding decisions. Due to the characteristics of the program, the positions of Assistant Director and Program Manager are fulfilled by the same person.

The Assistant Director/Program Manager provides continuous supervision to program activities and continually meets with specialists and supervisory personnel to review accomplishments, make technical decisions and to monitor the plan of activities. They also regularly meet with the Administrative Manager to analyze and prioritize the needs of technical personnel and offer answers, according to resources and capacity of the program. The Assistant Director represents a link between the technical area and the administrative area of the program and coordinates the work to reach the program objectives. The Assistant Director/Program Manager meets monthly with the technical personnel for more direct support. On occasion visits are made to the field to directly monitor activities that are happening there. The Administrative Management has also begun to make occasional visits to the field activities, to supervise the suitable handling of funds that are granted for the development of these activities.

The field supervisor provides support to the Assistant Director/Program Manager. The field supervisor spends 70.0% of the time in the field overseeing personnel, reinforcing coordination activities and supervising the local partners at different levels. The specialists are dedicated to reinforcing the specific activities of the program relating to their specialization. The field personnel work closely with agency partners, coffee proprietors' and community volunteers. They strongly support training activities and provide follow up and supervision to the local partners and community volunteers. The administrative program in general provides support to the technical activities of the program, in addition to its own administrative functions within the institution.

The technical personnel send monthly reports to their direct supervisor, who shares this information with the Assistant Director and the National Director. The project information is consolidated every three months and later analyzed by the agencies partners to determine how the objectives of the project are being reached. Technical and administrative reports are prepared on a trimester basis for the Central Office of Project HOPE as a tool that allows the technical and administrative personnel to monitor the progress of the project, in order to share that information with USAID and other potential donors.

The institutional fortification process that Project HOPE Guatemala initiated which gave life to the Strategic Plan has culminated the development of the Policies and Procedures Manual of the Human Resources Administration which was already used by personnel, finalized by the Interior of Work Regulation and is awaiting authorization from local work authorities. Both documents govern the most important aspects of the work relation between Project HOPE and it employees.

C. System of Communication and Team Development

Project HOPE Guatemala maintains a strict and appropriate process of communication towards the Central Offices of the Institution, at an internal level and with organizational partners. In addition to the monthly meetings, there are two trimester meetings whose objective is to give follow up with all of the personnel to fortify objectives raised in the Strategic Plan. Written communication is promoted to have a record of the decisions and actions taken, mainly those of a more important nature. The offices of Project HOPE Guatemala, use systems that permit agile, effective and efficient communication, from telephone and fax to more advanced systems like the intranet, email, and the internet which is used as a means to support virtual conferences. The technical personnel are the main means of communication for Project HOPE with their beneficiaries, partner organizations and also with program and coordination meetings, which has assisted in the development of the program.

D. Local partner relationship (How is the PVO doing as assessed by the local partner?)

The relationship with the local partners is well established. It is maintained through regular work meetings, joint supervision visits, the participation of the Country Director and Deputy Director in the Health Area council meetings at the department level, and the participation of Project HOPE staff in the MCH Commissions, which are workgroups under the Health Area Councils.

Overall, Project HOPE is a highly valued partner and this is expressed on many occasions including the midterm evaluation. MOH requests information about the migrant health activities from the districts in order to operationalize its migrant health program. Project HOPE is also continuously asked for technical assistance in the region. Project Hope's IMCI and RH trainers are rated as excellent trainers and the Health Areas and IGSS regularly ask for their support in providing such training. HOPE staff also participates in the national technical taskforces and the national opinion on the quality of training provided by Project HOPE is high.

E. PVO coordination/collaboration in country:

HOPE has a long history of coordination with local and international PVOs at the national level. The ones we are presently working with are: JHPIEGO, MOH, USAID Mission, International Labor Organization, the Order of Malta, and Aprofam (Pro-family Association).

With JHPIEGO, HOPE provides technical assistance in improving the quality of the Basic Maternal/Neonatal Medical Attention (AMNE) as established by the Reproductive Health Program of the Ministry of Health. In this endeavor, HOPE also coordinates with other agencies such as Red Cross, World Vision and Quality Health Project.

HOPE is working with MOH in the IMCI and community-IMCI/AINM-C Strategy. The project is responsible for assisting with capacity building, providing educational material and supplies

for implementation in priority areas. HOPE also coordinates with the Quality Health Project and World Vision in this effort.

HOPE and the USAID Mission hold a close relationship through Dr. Isabel Stout, a Mission officer.

With financial aid received from the International Labor Organization, HOPE developed the Child and Migrant Mother Health Initiative Program in the coffee plantations in four different municipalities. This program finished in April 2004.

In addition, Project HOPE maintains an active relationship with the Order of Malta for sending shipments of medications and supporting the Gift-in-Kind (GIK) program, which allows correspondents from the HOPE Center to support the Guatemala program.

Finally, APROFAM and Project HOPE are coordinating capacity building activities aimed to increase knowledge, skills, and attitudes of community personnel.

F. Other relevant aspects

The socialization and implementation of the Strategic Plan, has strengthened the image of the Institution at a local level. At an internal level, the trimester meetings with personnel have served to promote the mission, vision and values of Project HOPE Guatemala and its desire to maintain and continue to grow with the help of its most valuable resource, its personnel.

The specific stabilization actions, mainly those directed to assure the quality and impact of the actual programs and to fortify the institutional capacity in the Strategic Plan have advanced.

The opening of a Project HOPE office in Guatemala City has promoted the image of HOPE at a national level, favored the approach of local partners and donating agencies and has served in the search of spaces for involvement within OGS partnerships for the generation of new proposals, the search funds and technical assistance.

G. If an organizational capacity assessment of any kind has been conducted during the LOP, including a financial or management audit, describe how the PVO/program has responded to the findings

During the present year, an Internal Audit of Project HOPE Guatemala was carried out, which by objective reviewed: the policies and procedures relating to bank accounts and petty cash; policies and procedures on the use of vehicles, their correct identification and the corresponding insurance policies; the policies and procedures of travel expenses; the fulfillment of program obligations within the country; policies and procedures of Human Resources; fulfillment of labor laws, adapted salaries for personnel and a plan of continuation for Guatemala.

As a result of this study, actions have been implemented to improve the weaknesses that were found, such as to prioritize the policies and procedures section of bank accounts and petty cash in

the Financial Administration Manual, which is already in the development process. Overall the results of the Audit are satisfactory.

VIII. Work Plan for Next Year

On the following page the work plan for the fourth year of the program appears, there have not been substantial changes from the original work plan.

WORKPLAN FOR YEAR 4:

No.	OBJECTIVE	ACTIVITY	TERMS			
			1	2	3	4
1	COORDINATION	Health Area council meeting	X	X	X	X
		Coordination, plantation and monitoring meeting with MSP/IGSS/NGOs and property owners	X	X	X	X
		Development of graduation criteria with agency partners		X	X	
		Coordinate the exchange of information with the MSP in origin communities	X	X	X	
2	TRAINING AND SUPERVISION	Training/reinforcement for master trainers of Boca Costa and origin communities	X	X		
		Training for institutional health personnel in the interventions of the project	X	X		
		Training for institutional health personnel in the methods of Q1	X	X	X	
		Training of promoters of HU	X	X		
		Training of promoters of HU in first aid	X			
		Training of TBAs	X	X	X	
		Reinforcement training for institutional health personnel	X	X	X	
		Reinforcement training for promoters of HU	X	X	X	
		Reinforcement training for promoters and TBAs	X	X	X	
		Monitoring and supervision of institutional health personnel and community agents	X	X		
3	IMPROVEMENT OF SERVICES	Handling of infantile diseases and simple injuries in the HU	X	X	X	X
		Implementation of the Q1 exercises at an institutional health level	X	X	X	
		Development of new radio messages	X	X	X	X
		Transmission of basic health messages	X	X	X	
4	OPERATIONS RESEARCH	Test methods to improve utilization of the HUs by residents and immigrants	X	X		
		Plan and implement several mini studies		X	X	
		Cost of the HU and analysis of the cost benefit		X		
		Evaluate the impact of reviewing verbal cases and exit interviews in the establishment of health and practices of the promoters of the HU	X	X	X	
5	MONITORING AND	Fortification of the health information system of the MOH	X	X	X	

	AND EVALUATION	To make exit interview regular and verbal cases reviewed and feedback provided to the suppliers	**X**	**X**	**X**	
		To conduct data reviews every trimester and analyze the data with partners	**X**	**X**	**X**	**X**
		To regulate the smooth operation of health facilitators and of the HUs		**X**	**X**	
		Technical reports sent every trimester to the main office	**X**	**X**	**X**	**X**
6	**REVISION OF ANNUAL PROGRESS**	Development of an annual operative plan	**X**			
		Monitoring rounds	**X**	**X**		
		Final studies			**X**	
		Final Evaluation				**X**

IX. Does the Program Have Any Results or Key Successes or Has It Identified a New Methodology with the Potential for Eventual Development

With support from the Monitoring and Evaluation Director from HOPE Center, HOPE Guatemala implemented the application of a very fast tool for the collection of data and immediate analysis of the information collected in the surveys, through the use Personal Digital Assistants (PDAs) using the software programs Pocket PC Creation (PPCC), MS Excel and Epi-Info. In September of 2003 as part of the mid-term evaluation, a KPC survey was conducted to collect data at the household level using the described technology. The experience was good because the survey personnel became trained in the use of PDAs, the interviews were developed in less time and the analysis was rather fast because the information was computerized at the time of the survey making it no longer necessary to separately enter each ticket and the collected information served immediately to form the indicators by using the Epi-Info program.

In this survey 12 of the indicators of maternal and child health at the home level, related to education and health prevention were reported to be low compared with data from the base line made in 2001. As part of the mid-term evaluation, an action plan was developed that also included an aggressive IEC plan to intensify educative actions and in addition activities were programmed to monitor specific indicators that showed weakness. One of the indicators that was the most concerning was the percentage of children from 12 to 23 months with a complete scheme of immunizations went down to 50% from the reported percentage in 2001. By analyzing this data at great length we noted that an error possibly occurred in the crossing of data from one base to another or that in some passage similar to that the information was lost, in addition we believe that the necessary time was not given to the mothers to find the child's ID card and it was accepted when the mothers said they did not have it. To form the indicator only the information on the ID card was used. The information collected from the ID card was compared with the information of the health establishments and great differences were noted and of the 29 (21.6%) children younger than 23 months with a complete scheme that the survey reported, the number rose to 82 (61%). In September of 2004 a monitoring round was made using the methodology of LQAS to track the 12 described indicators and the results were very positive. In this survey the great care was taken to use triangulation of the information. The surveyors that solicited information from the mothers insisted on obtaining the child's ID card and a fewer surveys were done each day providing more time to wait for the mother to give the card and in addition the surveyors took the registry that the health service uses for the communities where they had done surveys and with that they could compare information from three different sources, which allowed them to have more real and objective data.

X. If the Guidelines Do No Apply to the Program

It does not apply.

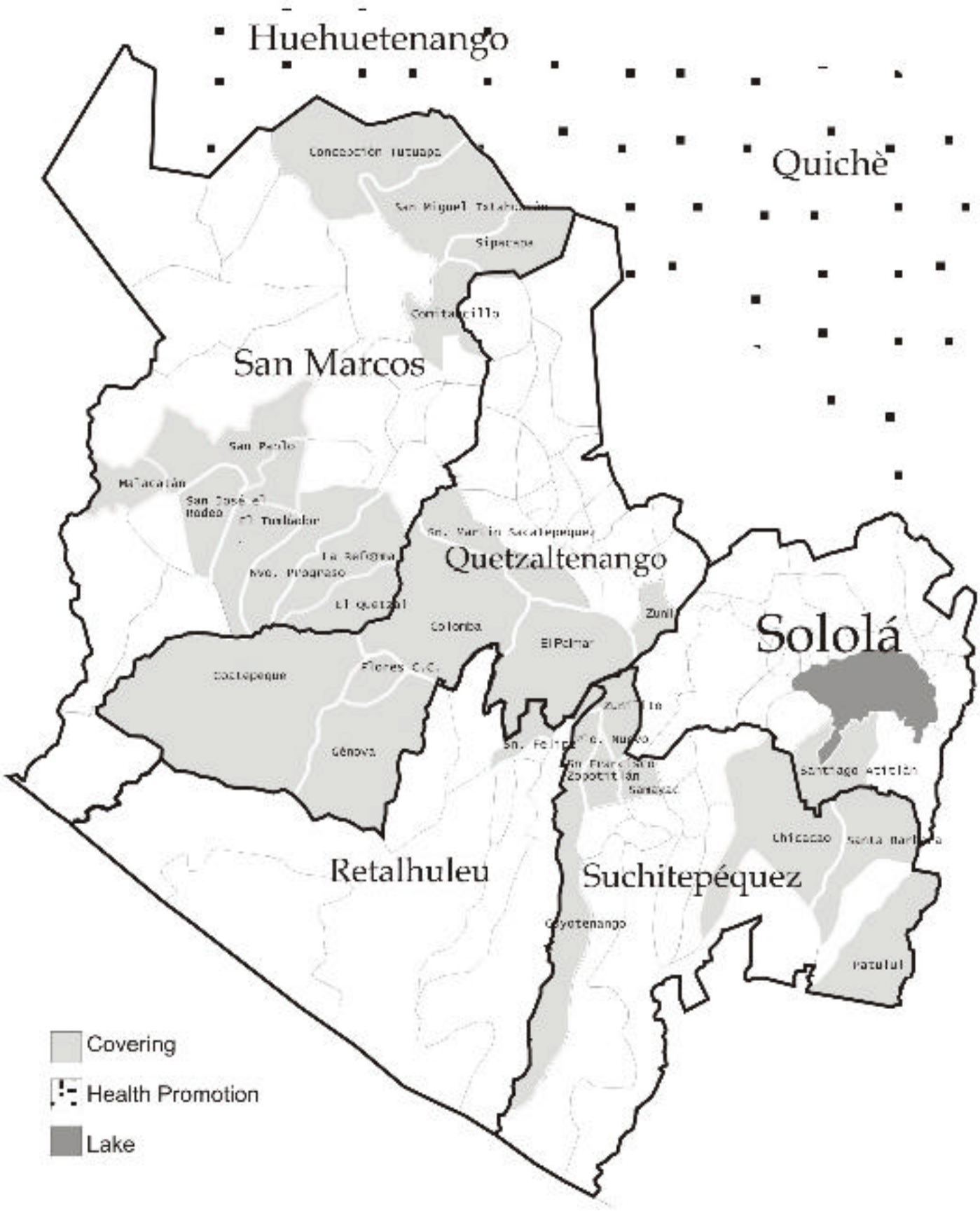
XI. Other Relevant Aspects

It does not apply.

ATTACHMENTS

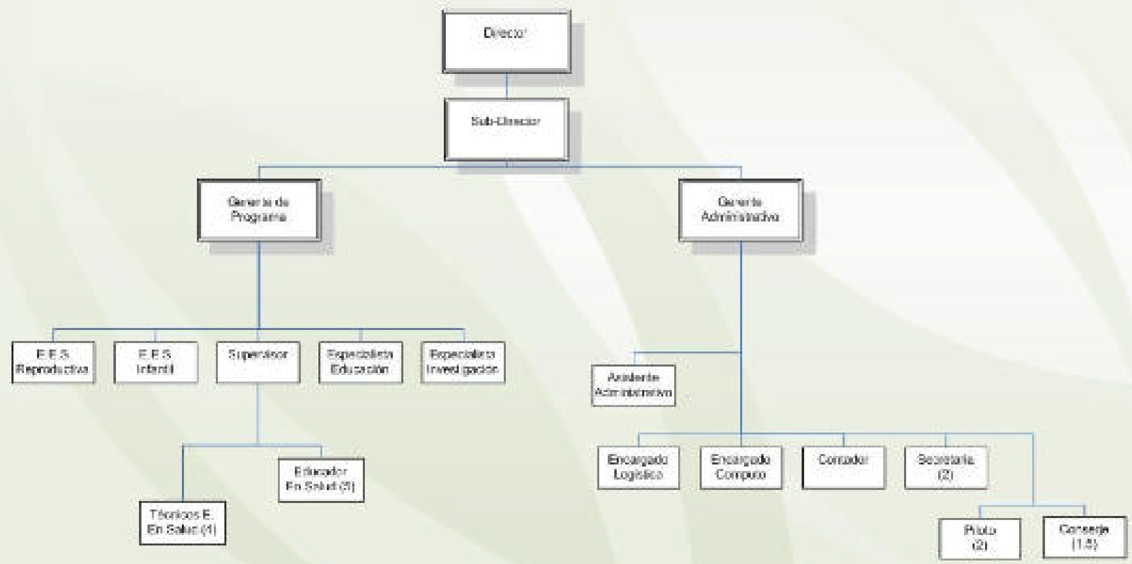
ATTACHMENT 1:
MAP OF PROJECT IMPLEMENTATION AREAS

LOCATION OF CHILD SURVIVAL PROGRAM
PROJECT HOPE, GUATEMALA



ATTACHMENT 2:
ORGANIZATIONAL CHART

ORGANIGRAM
Project HOPE Guatemala
CHILD SURVIVAL PROGRAM



ATTACHMENT 3:
BASIC HEALTH CARE UNITS STUDIES

3.1 PERFORMANCE OF HEALTH PROMOTERS
3.2 CLIENT SATISFACTION
3.3 SITUATIONAL ASSESSMENT

ATTACHMENT 3: BASIC HEALTH CARE UNITS STUDIES

STUDY #1: PERFORMANCE OF HEALTH PROMOTERS IN REGARD TO THE INTEGRATED MANAGEMENT OF IMCI AINM-C STRATEGY CASES AND THE ATTENTION RECEIVED IN THE BASIC HEALTH CARE UNITS IMPLEMENTED IN THE MUNICIPALITIES OF THE BOCA COSTA REGION OF SAN MARCOS, QUETZALTENANGO AND SUCHITEPEQUEZ. JULY 2004

Summary

The objective of this study was to identify the strengths and weaknesses of health promoters on the Integrated Management of IMCI AINM C Strategy Cases, and design a follow-up plan. The performance monitoring was conducted by observing the promoters at work in their basic health care units, and the application of the skills acquired during their training.

Introduction

The Integrated Management of Childhood Illness (IMCI) arises as a means to reduce infant mortality in this age group caused by preventable and/or curable diseases, which can be avoided or treated via the application of appropriate evaluation, classification, treatment and follow-up guidelines, and adequate family counseling on the care of children at home.

To contribute to the reduction of infant mortality related to the causes mentioned above, since 1997 Project HOPE, via its Child Survival program, has implemented jointly with the Ministry of Health, farm owners, managers and the IGSS, a strategy for raising coverage through the creation of basic health units on coffee farms in Boca Costa, to facilitate access to health services both for residents and the migrant population.

Training has been provided to the promoters of the IMCI Community strategy on the Integrated Management of Cases and Promotion and Prevention. Every month follow-up to this training is coordinated with the promoters and their health districts in order to strengthen their skills and knowledge.

This report contains the results of the performance monitoring and evaluation study relating to the Integrated Management of IMCI Community for volunteers at the basic health units in Boca Costa of San Marcos, Quetzaltenango and Suchitepequez, which took place during the month of July 2004.

General Objective

The general objective of the study was to evaluate the performance of volunteers in regards to the strategy for the Integrated Management of IMCI Community Cases and the attention provided at the basic health units in Boca Costa of San Marcos, Quetzaltenango and Suchitepequez during the month of July 2004.

Methodology

The sample consisted of 128 health promoters who had received training on IMCI AINM – C strategy, and who cares for patients at the basic health units that have been set-up at farms and communities in areas covered by the Child Survival program implemented in the Department of San Marcos, Quetzaltenango and Suchitepequez. A total of 135 promoters were considered for this study.

The tool used for the monitoring and evaluation study of the performance relating to the integrated management of IMCI community cases was adapted from evaluation performance tools on IMCI strategy for clinic staff to the volunteers. The evaluation took into consideration all elements relating to integrated child care on which the health promoters had received training, including: evaluation, classification, treatment and counseling.

Doctors, nurses and field technicians from the Project HOPE Child Survival program participated in the compilation of data, with the support of the Rural Health Auxiliary Nurses and Technicians at the health centers or posts within the jurisdiction of the communities selected for the study, and the Guatemalan Social Security Institute (IGSS). The study was conducted by: IT specialist, Child Survival program supervisor and the project administrative staff.

Prior to the data compilation, the persons responsible for the study were trained, the survey form was reviewed and the instruction sheets were given to all. Each technician prepared an access route to the selected communities and prepared a chronogram for the data compilation. Notes were prepared for the various areas, health districts, owners and/or managers of farms/plantations, with information on the study to be performed and requesting their assistance in the visitation of communities and farms/plantations. The data compilation took place from June 22 to August 8, 2004.

Each person collecting data was responsible for a personal digital assistant (PDA), which had to be returned at the end of each day in order to download the information.

For the data tabulation and analysis, a database review was performed to thus eliminate errors presented when entering the information. The data tabulation and analysis was performed using the EIP Info 6.0 program, which statistically relates the study variables applying variable cross sections and frequencies.

Results

Taking into consideration the evaluation, classification, treatment, counseling and follow-up guidelines used to train the health promoters, the performance evaluation tool was applied. This tool required the promoter to visit a child under 5 years old. If none of the patients qualified under this category, a hypothetical case was narrated, per prior validation with technical staff at the program offices.

A total of 94.5% of the observations performed by the health promoters at the basic health units related to cases of children ranging from 2 months to 5 years, coinciding with the age group authorized to have their case reviewed at the basic health unit.

Per the results obtained under the first section of the Evaluation "Question and Observation" of the four main danger signs for children ranging from 2 months to five years: 35.2% of the patients were evaluated when they were attended, but 62.5% were not. If the general danger signs are not identified and treated in a timely and adequate manner, permanent damage, incapacity or death may occur.

Regarding ear and throat problems, 31.0% of the cases were investigated and 66.6% were not. This creates cause for concern as these problems are not evaluated if they are not referred to by the mothers. In regards to diarrhea, 42.9% of the cases were investigated and 56.3% were not, revealing the need to strengthen the investigation of this problem as it is one of the main illnesses affecting the child population. Of the cases of fever, 56.3% were investigated and 43.7% were not and regarding the nutritional status 26.6% were investigated and 73.4% were not. In regards to feeding problems, 28.1% were investigated and 71.9% were not and the verification of the vaccination status of the child was performed in 36.2% of the cases, and for 63% it was not. The evaluation of other health problems was investigated for 28.3% of the cases, and for 68.5% it was not.

The second phase of the Integrated Management of Cases is classification. Of the observations performed 21.4% of the promoters correctly classified the danger signs, and 69.1% did not. Coughing and respiratory problems were correctly classified in 45.3% of the cases, and in 50% were not. Ear and throat problems were correctly classified in 21.1% of the cases, and in 63.3% were not.

Of the cases of diarrhea, 33.6% were correctly classified in 33.6% and 52.6% were not. In regards, to cases of fever 39.1% were classified correctly and 52.3% were not.

The nutritional status was classified correctly in 21.1% of the cases, and incorrectly in 76.6%. Regarding vaccinations, 28.9% of the cases were classified correctly and 70.3% were not. The correct referral was made in 17.2% of the cases, and in 28.9% it was not. A total of 53.9% of the observations did not require referral and do not apply. In cases where a child as referred, classified and received the correct medication, 52.4% were done and 39.8% were not.

The third phase is treatment, and for the promoters most familiar with this the necessary guidelines for each case were included. Of these, 41.4% used the guides, and 57% did not. In regards to the third phase counseling, of equal importance as the previous phases, 43% of the materials given to mothers regarding the illness of their child were correct and 55.4% were incorrect.

Nutritional counseling was provided in 21.1% of the cases, and 78.9% did not receive counseling, thus demonstrating it is not being given the importance it merits. Counseling on vaccinations was provided in 31.3% of the cases, and 67.9% did not receive counseling.

The verification questions were performed correctly in 30.5% of the cases, and incorrectly in 67.2% of the cases.

Under the program, all promoters have received the materials required for the integrated management of cases. Per the evaluation of the support material for evaluation, treatment and counseling 32.8% of the promoters are using them, and 64.8% are not.

The registration of information is of vital importance, and for this the Management Information System of the Ministry of Health is used. Per the evaluation, 50.8% of the promoters are registering the information correctly and 44.5% are not.

Conclusions and Recommendations

The majority of the promoters are not observing if the child is presenting a danger sign, and are dealing directly with the problem or the symptom referred by the mother or at the time they are checked per the specific demand from the mother. They are not considering possible danger signs and may merit an urgent management referral to another service and thus it is necessary to continue to emphasize the identification of danger signs when evaluating children under 5 years old. If these situations are not identified and handled in a timely and adequate manner, permanent damage, incapacity or death may occur.

- Malnutrition is considered so normal in our environment that not even the health services are concerned about identifying these deficiencies in children when they are checked. It is necessary to strengthen this area, because unless the nutritional status of children does improve, the nutrition-infection cycle will continue.

- It is disturbing to verify that the status of a child's vaccinations is not checked in most cases. It is a very important issue and presented as such during training by asking health promoters to review the vaccination cards of all children under the age of five, and to apply what they have learned by verifying the status of a child's vaccinations using a chart detailing their age. This verification is extremely important to the integrated management of cases.

- In light of the fact that in the research performed not all of the child's problems are identified, the existence of other problems must also be considered at the time of the check-up, but in many cases the mothers give priority to what originated the visit (what is most evident at that time). The evaluation of other problems in many cases would not be the responsibility of the health promoters, but they can facilitate counseling so attention is duly provided.

- In spite of enabling an adequate atmosphere of trust and providing the necessary information as relates to the visit, at the time of the check-up many health promoters seemed nervous on how to proceed, and without doubt the term "evaluation" continues to be a synonym of "repression" and causes fear, and not human development where we can all learn. It may also have been related to the fact that the persons sent to observe them were not the technician they were

familiar with but other program staff. In some cases the technicians were present, but not necessarily.

- It was noted that it is customary to register the cases in a notebook designated for this purpose, possibly due to the fact that the Ministry of Health does not always provide the necessary office supplies. It may also be due to the fact that although they have been trained, it is difficult for them to register the information. Due to this, a procedure is being tested for the implementation of a registration form for children under 5 years old linked to the IMCI AINM–C strategy. Developed and implemented by PROREDES, this is a tool of the Ministry of Health's information system that has been modified and adapted to IMCI to facilitate the work of the promoters.

- While evaluating the skills related to the management of specific cases such as ARIs (cough and cold, pneumonia and severe pneumonia) it was noted that the promoters for the most part adequately managed the problem, but do not evaluate all aspects per the guidelines for integrated management. In view of this situation, what is identified is the lack of understanding how to establish integrated management of each case rather than a lack of skills or materials. Due to this, promoters should be accompanied more while at their basic health units, and receive tutorial support relating to real cases rather than training sessions.

- In conclusion, what is observed is that the development of the complete process of integrated management of cases is still difficult for the health promoters, even when support materials are provided. The vision for the integrated management of cases relating to children needs to be strengthened per the methodology utilized, and which would enable the result expected per the IMCI strategy via an action plan directly linked to the knowledge and skills of the health promoter per the weaknesses detected. Traditionally, the health promoters and health services are used to only responding to the motive of the visit.

STUDY #2: CLIENT SATISFACTION IN REGARDS TO THE SERVICES PROVIDED BY THE BASIC HEALTH CARE UNITS IN THE BOCA COSTA REIGON OF SAN MARCOS, QUETZALTENANGO AND SUCHITEPEQUEZ, JULY 2004

Summary

This study was performed to determine user satisfaction when utilizing the services of the basic health units in Boca Costa of San Marcos, Quetzaltenango and Suchitepequez. It was determined that the users interviewed have had to visit the health promoter at least once in search of counseling or assistance. They were asked about the attention they received, their trust in the attention and treatment, schedule and cost of the visit and medicines, among other things. This study took place during the months of July and August 2004.

Introduction

The Integrated Management of Childhood Illness (IMCI) arises as a means to reduce infant mortality in this age group caused by preventable and/or curable diseases, which can be avoided or treated via the application of appropriate evaluation, classification, treatment and follow-up norms, and adequate family counseling on the care of children at home.

Due to this, it is necessary to constantly supervise and monitor the development of these processes within the basic health units implemented by the program for the scaling-up of the coverage of health services for children under 5 years old per the IMCI AIEPI – C strategy. The main provider of services is the trained health promoter with the technical assistance of health personnel. It is necessary to identify if the strategy has been accepted and/or recognized by the users as an immediate response they can trust for the health of their children while they are ill.

This report details the results obtained from the study on user satisfaction at the basic health units in Boca Costa de San Marcos, Quetzaltenango and Suchitepequez performed during the months of July and August 2004.

General Objective

The general objective of this study was to determine the satisfaction of the users of the health services provided by the promoters at the basic health units located in Boca Costa of San Marcos, Quetzaltenango and Suchitepequez during the month of July 2004.

Methodology

The sample used for this study was made up by 369 mothers of children less than two years of age living in communities where a health intervention has been implemented under the Child Health Program, and who have had at least one check-up at the basic health unit in their farm or community.

The questionnaire used for the study on user satisfaction consisted on 14 questions covering topics such as: the first person or place the mother goes when their child is ill, the number of visits made to a basic health unit, confidence in the attention and treatment received, schedule, patient referral and cost of visit and medicine at the basic health unit. This tool was validated and the necessary changes were made.

To select the study sample, each visit to a basic health unit was reviewed, both those located on farms as in communities participating in the Child Survival Program, and interviews were scheduled with a maximum of three mothers of children less than two years of age who had visited a basic health unit at least one time per visit (the minimum being one mother). For all the woman interviewed were asked to collaborate and agreed to answer the questions. In cases where the woman was related to the promoter, another person was identified and interviewed in their place.

Doctors, nurses and field technicians from the Project HOPE Child Survival Program participated in the data compilation, with the support of the Rural Health Auxiliary Nurses and Technicians at the health centers or posts within the jurisdiction of the communities selected for the study, and the Guatemalan Social Security Institute (IGSS). The study was conducted by: IT specialist, Child Survival Program supervisor, project administrative staff and a consultant.

Prior to data compilation, the persons responsible for the same were trained, the survey form was reviewed and the instruction sheets were given to all. Each technician prepared an access route to the selected communities and prepared a chronogram for the data compilation. Notes were prepared for the various areas, health districts, owners and/or managers of farms/plantations, with information on the study to be performed and requesting their assistance in the visitation of communities and farms/plantations. The data compilation took place from June 22 to August 8, 2004. In the communities and farms where access was very difficult or impossible to visit, or the promoter was not available, a second visit was considered per a new visit plan for the program staff.

Each person collecting data was responsible for a personal digital assistant (PDA), which had to be returned at the end of each day in order to download the information. In cases where there were questions regarding an answer, the person who performed the interview was consulted for clarification. After this, the data was tabulated and analyzed.

For the data tabulation and analysis, a database review was performed to thus eliminate errors presented when entering the information. The data tabulation and analysis was performed using the EPI Info 6.04 program, which statistically relates the study variables applying variable cross section and frequencies. The information was analyzed based on the frequency of the answers received by the mothers of the children who had visited the basic health unit at least once for a check-up.

Results

It was noted that the basic health units are the main places visited by mothers of children under 5 years old (88.7%), followed by health centers or posts (6.2%) and private doctors (3.2%).

In regards to how they view the attention received by the promoter at the basic health unit, 89.5% considered the attention to be good, and 8.9% consider it to have been bad.

Of the mothers interviewed, 96.7% said they trusted the treatment and attention received from the health promoter when their children are ill.

The working hours of the basic health units was considered good by 86.4% of the mothers interviewed, and 13.6% considered it was not adequate.

In spite of the limitations experienced by health promoters in providing services during working hours, 88.3% of those interviewed stated that the health promoter was attended them outside of working hours when a child was ill. This means that the work of the health promoters in farms or communities is very important as they are the first person

contacted when advice or assistance is needed for sick children, and they are contacted at any time during the day or night.

Of the mothers interviewed, 72.9% indicated that the health promoter refers the patients to other services when seriously ill, and 19.5% stated they were not aware of what the promoter does as they have never needed to be referred, and 7.6% indicated the promoter provided the attention needed, which implies that families need to be made more aware of danger signs so they can determine the importance of timely referrals to avoid death or complications for a seriously ill child.

The mothers of children less than two years of age when they have a seriously ill child and need to go to another health service, 77.8% indicated that they do take them, otherwise they would risk possible death, and 19.5% indicated they sometimes take them, which confirms that it is necessary to reinforce families on danger signs so they are aware of the importance of timely referrals to avoid death or complications for a seriously ill child.

In 87.6% of the cases, the mothers indicated that the health promoter provides assistance or advice on how to care for their children in order to prevent illnesses, and also what to do when they are ill.

In regards to the medicines required when a child is ill, 85.4% of the mothers indicated that when they do receive medication at the basic health unit in most cases it is because of the owner and/or manager of the farm has purchased the medications, but in many cases the medications are for adults, and for the most part are pain killers or first aid supplies, apart from what is provided by the Ministry of Health. 10.5% of the mothers stated they are not given medications when their children are ill, which means they must buy it at a drug store or pharmacy, which are not always accessible.

In addition, 84.3% indicated they do not pay for visits to the basic health units, but 14.1% do have to pay. According to the answers of the mothers interviewed, 20.1% agree with paying for the visit, but 79.9% do not consider that they should pay for the attention provided by the health promoter at the basic health unit.

The medications provided at the basic health unit are free for 80%, of the mothers interviewed, but 15.7% do pay for the medications and 3.5% are sometimes required to pay. The Ona de El Quetzal faro in San Marcos organized the purchase of medications at a pharmacy in Coatepeque, Quetzaltenango. When a health promoter prescribes medicine for a sick child and the mother authorizes the purchase, the medicine is delivered and the mother is billed. A total of 77% of the mothers interviewed indicated they do not agree with paying for the medications they need, and would prefer to obtain medications so that when someone is sick they can use them and not have to incur in additional expenses due to their extremely poor economic situation and the extreme poverty of the communities and farms that depend basically on coffee crops.

Conclusions and Recommendations

- According to these results, what is noted is that the strategy for increasing the coverage of health services at the basic health units through the training of health promoters to respond to the main health needs of the community is extremely important for the users. Based on their answers, they consider that it is one of the factors that have made it possible for the population to have immediate health services with trained human resources from their own community that they can refer to at any moment.

- In spite of the fact that the health promoters are for the most part volunteers offering their services, and limited by the available supplies and medications as the Ministry of Health does not always provide the necessary resources, the result of user satisfaction are quite encouraging.

- There are a small percentage of users who state they are not satisfied with the attention received, especially when they have required attention and no medications were available and they had to go somewhere else, mainly a health center or post. This situation does not depend on the promoters but on the capacity of the health services required to support the health units.

- The health promoters are a vital resource for the referral of cases to health services and are constantly receiving training emphasizing the situations which require urgent attention for children under 5 years old as determined by the IMCI strategy. According to the results obtained, the pertinent referrals are being made at the level required, although some promoters are obliged to deal with seriously ill children in the community due to the family's refusal to take them elsewhere or due to financial constraints or lack of transportation at the time the emergency occurs (usually late at night).

- Sometimes mothers are not able to take their sick child to a health center per the referral of the promoter due to the great distance involved and having to walk, or otherwise be able to cover the expense of transportation, meals, lodging, etc. Another aggravating issue is who will take care of their home and care for their husband and other children if the mother is with the sick child. One option is to strengthen the family and community emergency plans so these situations can be foreseen and risks minimized.

- In spite of the economic crisis, which has forced the Ministry of Health to reduce the supply of medications to health services, a high percentage indicated receiving medications when required.

- When the health promoters charge a fee it is relatively small and in most cases due to the fact that they do not have another job and work fulltime attending to patients in the basic health units. This occurs mainly in the basic health units located in the communities, where they receive no type of support, and conscious

of this situation they agree to pay, although most would prefer the visit to have no charge.

- At some basic health units the promoter buys medications with their own funds to have available for patients, and in these cases they resell them to the mothers. If the medications are provided by the Ministry of Health, they are never sold. In other cases, the owners and/or managers of the farm buy the medications for resale. A high percentage of users indicated they would prefer free medications, which is understandable due to the extreme poverty in which they live.

- According to the results, the strategy has been largely successful as most of the users report being satisfied with the services of the health promoter. This is observed by their visits to the basic health units (house of the promoter or specific office) when they need support in caring for the child. The promoter is the first person they contact for help, demonstrating the trust they have in the promoter for the care and treatment of their children and at the same time the response of the promoter by serving their community at all hours and their counseling being well received by the community who recognizes them as a person who has received the necessary training to help them.

- The data shows that the health units are a very important resource for the community, mainly due to the poverty and retarded conditions many are in, and the health promoter is their only hope of care for their children as going to another health service implies a higher expense.

- The Ministry of Health, the owners and/or manager of coffee farms and the communities themselves need to strengthen this strategy, identifying the means and resources required for its operation, especially taking into consideration financial remuneration for the health promoters, permanent training, supervision at their posts, availability of supplies and medications, and facilitating the tools required for health education and counseling. Taking into consideration that the basic health units play a very important role for the Ministry of Health by enabling access to health services for these populations, thus reducing the number of persons who visit health centers and posts as they are able to receive attention in their communities (and only serious cases are referred by the promoter when unable to provide the necessary attention), there is an increase in the capacity of health services to respond to the rest of the needs of the population.

STUDY #3: SITUATIONAL ASSESSMENT OF BASIC HEALTH CARE UNITS IN THE BOCA COSTA REGION OF SAN MARCOS, QUETZALTENANGO AND SUCHITEPEQUEZ, JULY 2004

Summary

This study was performed to assess the current situation of basic health units in La Boca Costa de San Marcos, Quetzaltenango and Retalhuleu, where the health promoters provide services. Four basic aspects were considered: the performance of the health promoter, the current situation of the basic health units, the involvement of the partners and/or managers of the farms and the satisfaction of the promoter within the framework of the basic health unit. This study took place during the months of July and August 2004.

Introduction

Considering that health is a human right recognized by international agreements and national legislation, the responsibility for ensuring this right belongs to the State who must direct the necessary public funds and guarantee social participation. The population has the right to receive integrated care, as well as living conditions and resources necessary to be healthy. However, they also have the obligation to care for their health and participate individually or jointly in demanding the right to health reflected in public policy, programs and health actions.

In order to contribute to the reduction of child mortality rates, since 1997 Project HOPE via its Child Survival program has implemented jointly with the Ministry of Health, owners and/or managers of farms, and the IGSS, a strategy to scale-up coverage through the creation of basic health units on coffee farms in the Boca Costa to facilitate access to health services for the migrant and resident mother and child population in this area. Commitments were determined for all the participants, for example, the owners and/or managers provide a basic furnished space and designate a person to be trained to provide the unit services, in some cases they are paid a salary and for others it is included within their responsibilities on the farm. The Ministry of Health provides medications, monitoring and monthly trainings. The IGSS in Suchitepequez supports the Ministry of Health (except with the medications), and Project HOPE supports all those involved, especially the Ministry of Health in monitoring the strategy, training for health promoters, identifying funding, training materials, education and supervising the health promoters at work in order to strengthen their skills.

In order to identify the strengths and weaknesses, and draw up a follow-up plan, an assessment was made on the situation of the basic health units under the Child Survival Program in La Boca Costa of San Marcos, Quetzaltenango and Suchitepequez. This reports details the results of this study.

General Objective

The general objective of the study was to perform an assessment of the situation at the basic health units located on farms and in communities under the Child Survival program in La Boca Costa of San Marcos, Quetzaltenango and Suchitepequez.

Methodology

The study covered 135 basic health units representing 87.1% of the total of 155 units currently operating on farms and in communities under the Child Survival program in La Boca Costa of San Marcos, Quetzaltenango and Suchitepequez. These were the units at which it was feasible to perform the study at that time. In the selection process each visit to the basic health units was considered, whether located on farms or in the communities.

The questionnaire that was used for the assessment of the current situation of the basic health units was adapted from an instrument utilized in a study performed in 2002. This instrument comprises 41 questions. Four basic aspects were considered: the performance of the health promoter, the current situation of the basic health units, the involvement of the partners and/or managers of the farms and the satisfaction of the promoter within the framework of the basic health unit.

Doctors, nurses and field technicians from the Project HOPE Child Survival program participated in the data compilation, with the support of the Rural Health Auxiliary Nurses and Technicians at the health centers or posts within the jurisdiction of the communities selected for the study, and the Guatemalan Social Security Institute (IGSS). The study was conducted by: IT specialist, a Child Survival program supervisor, project administrative staff and a consultant.

Prior to data compilation, the persons responsible for compiling the information on the assessment of the situation of the basic health units were trained. Some of the questions were for observation, the form was reviewed and the instruction sheets were given to all. Each technician prepared an access route to the selected communities and prepared a chronogram for the data compilation. Notes were prepared for the various areas, health districts, owners and/or managers of farms/plantations, with information on the study to be performed and requesting their assistance in the visitation of communities and farms/plantations. The data compilation took place from June 22 to August 8, 2004. In the communities and farms where access was very difficult or impossible to visit, or the promoter was not available, a second visit was considered per a new visit plan for the program staff.

Each person collecting data was responsible for a personal digital agent (PDA), which had to be returned at the end of each day in order to download the information. In cases where there were questions regarding an answer, the person who performed the interview was consulted for clarification. After this, the data was tabulated and analyzed.

Priori to the tabulation and data analysis the entire database was reviewed to eliminate errors presented when entering the information. The data tabulation and analysis was performed using the EIP Info 6.0 program, which statistically relates the study variables applying variable cross section and frequencies. The information was analyzed based on

the frequency of the answers received from the basic health units currently operating on farms and in communities under the Child Survival program in the Boca Costa of San Marcos, Quetzaltenango and Suchitepequez. These frequencies were made based on the incidence of the answers relating to the observations and the corresponding percentages.

Results

According to the results obtained from this study we were able to observe that 50.4% of the basic health units are located on farms and 49.6% in communities.

I. PERFORMANCE OF THE PROMOTER

A. SUSTAINABILITY

It was noted from the results that 100.0% of the basic health units have a promoter. This means that of the 135 basic health units visited, all have a person who can provide attention when a person is sick, either due to illness or a work accident. In addition, 75.5% of the promoters interviewed indicated that they had been in the position for over a year, 15.6% have been in the position between 3 months to 1 year, and 8.9% have been in the position less than 3 months. Due to this all have experience in the management of patients who require counseling or care while sick. Regarding the type of services offered at the basic health units, 75.6% of the promoters do not receive remuneration, 16.3% are paid by the farm but have additional responsibilities (this means that they have to take time out of their daily work schedule to attend the basic health unit), and 8.1% are paid by the farm and work full-time at the basic health unit (this is the case mainly on those farms that have not been affected as much by the drops in the prices of coffee, and where the owners and/or managers of the farm are aware of the importance of the health of their workers during their time on the farm).

B. TRAINING ON IMCI

In regards to this aspect, the only question made to health promoters was if they had received training on the IMC strategy, as a second study was being performed specifically on the performance of promoters relating to the integrated management of cases using the IMCI AINM–C strategy in the basic health units located in the municipalities of the Boca Costa of San Marcos, Quetzaltenango and Suchitepequez under the Child Survival program. The results indicated that 88.1% of the health promoters interviewed had received training on IMCI and 11.9% had not received training due to work-related issues they were unable to participate in the workshop but they are participating in the monthly meetings.

C. AIEPI PROMOTION AND PREVENTION

It was observed that 85.2% of the health promoters interviewed had received this training, and 14.8% had not received training due to the same reasons as mentioned above. This training was an activity that complements the AIEPI (IMCI) training, and emphasis should be placed on this in order to take advantage of the human resources located at each basic health unit. The health promoters stated that 42.2% used the daily visits from mothers to provide counseling relating to health topics for mothers and

children under 5 years old, such as family planning, family emergency plan, IRAS, diarrhea, malnutrition, anemia, vaccinations, STD/HIV, home hygiene, community participation, dengue and malaria. In addition, 25.0% organize groups and talks once a month, 14.8% twice a month and 18.0% do not organize any event. These last require strengthening on the strategy, as 43.5% indicated that the mothers do not participate in these types of activities, and 34.8% do not have the time or materials necessary and 26.1% feel that lack training and a venue to use.

D. ASSISTANCE AT MONTHLY FOLLOW-UP MEETINGS

Of the promoters interviewed, 93.3% indicated that they do participate in the planned monthly meetings; only 6.7% do not participate as 33.3% do not receive authorization from the farm to participate and 55.6% do not receive notification. A total of 50.4% of the promoters have attended all of the last three monthly follow-0up meetings, 25.2% attended two, 11.9% attended one and 12.6% did not attend any of the meetings.

E. MORBIDITY REPORTS

Of the promoters interviewed, 87.4% indicated that they report monthly on the patients attended at the basic health units, and when the arrive at the follow-up meetings they submit these to the nurse at the corresponding health center/post, 5.9% submit reports every two weeks, but 6.7% do not prepare any report meaning that the work of the promoter at the basic health unit is not registered. It is extremely important to document all the work and procedures made to support the argument of why basic health units are part of the national health system.

F. AVERAGE REFERRALS AND VISITS IN THE PAST TWO WEEKS

In order to determine the average of references and visits received in the past two weeks by the health promoters at their basic unit, they were asked to submit the SIGSAS in use at the time and/or the notebook where they record the daily list of patients. According to these, 77.1% had not made any referrals as they were not necessary, 20.7% had made 1-5 referrals in the past two weeks, and 2.2% said they did not know how to issue a referral. Among the referrals made, the promoters indicated that 8.9% are issued due to accidents or emergencies, 5.2% due to severe pneumonia, 3.7% due to diarrhea with severe dehydration or persistent and signs of risk due to pregnancy, birth or postpartum, 2.2% due to fever, 1.5% due to vaccinations or incomplete vaccinations, and 0.7% each due to the illness of children less than two months, malnutrition and anemia.

The average of patients attended by the health promoters in the past two weeks was mainly (54.1%) between 1 to 10, and 26.7% attended 11 to 20, 7.4% attended 21 to 30 and 3.7% attended more than 20. In addition, 8.1% had not attended any patient during the past two weeks. The age group most attended was children between 0-10 years (78.5%), followed by male adults (11.9%), adolescents (11-18 years) and women of reproductive age/pregnant (3.7% each) and the elderly (2.2%).

G. PARTICIPATION IN HEALTH ACTIVITIES

Under the framework of the strategy for the implementation of the basic health units and the participation of the promoters in health activities carried out on their farm or in their community, they were asked about their participation in the planning and coordinating of health activities with the Ministry of Health. They indicated that 43.7% participate in this process, 57.0% participate in the promotion of health activities and 40.0% organize health activities, 37.8% verify the environmental health conditions, 37.0% visits wards or homes to identify sick children and 32.6% do not participate in any of the above-mentioned activities.

II. BASIC HEALTH UNITS

A. LOCATION

The improvement of health services is essential in order to ensure that all Guatemalan have the opportunity to exercise their right to a long and healthy life. One of the first steps required in order to achieve this objective is to ensure that no person, especially women or children, die of preventable and/or curable illnesses. This assessment determined that the infrastructure of 54.8% of the basic health units are located at the promoter's house, 40.7% in facilities provided by the farm and 4.5% in community facilities.

B. LOCAL

The percentages obtained regarding the conditions of the facilities used for basic health units are very satisfactory. It was considered that 90.4% have the necessary hygiene, 94.1% have the necessary lighting, 96.3% have the necessary ventilation, 59.3% the privacy required to attend patients (due to the fact that they are working out of the promoter's house and do not have specific facilities for the basic health unit).

C. EQUIPMENT

One of the weaknesses is the equipment at the basic health units as only 77.8% have a timer (used to count breathing frequency). This equipment was delivered by Project HOPE to the promoters, who received training on AIEPI (IMCI), but in some cases they have deteriorated or been lost, and not all have one. In regards to the oral thermometer, only 45.9% have one, and it is very important for the basic health unit to include a thermometer in their equipment as it is necessary to take the temperature of patients requiring attention. However, under the strategy they have received training on different techniques on how to take body temperatures or without using thermometers. Only 19.3% have a scale, which means that they are unable to determine the nutritional status of children, and those who have scales utilize the ones that require standing and are not very specific for children less than two years of age. In some cases, the same scales are used to weigh coffee, and the procedure is to weigh first the mother and then the mother holding the child.

D. FURNITURE

According to the results, only 61.5% have a stretcher, 88.1% have a table (which is very important as it is where the promoter sits while talking with the patients) and 92.6% have chairs (including in these those with wooden or plastic stools). In addition, 82.2% have shelves for medications, and 34.8% have screens or curtains, to ensure privacy while attending patients.

E. STATIONERY AND EDUCATIONAL MATERIALS

The minimum stationery requirements for a basic health unit are daily registrars for visits and tools for registering talks and supervision of the basic health units. It was determined that 86.7% have the AIEPI portfolio and educational guides (sheets), 87.4% have the AIEPI evaluation and treatment guides, 86.7% have the Ministry of Health forms (SIGSAS), 38.5% have form four for reporting on talks, 45.2% have the supervision tools provided to the basic health units and only 25.2% have notebooks for registration.

F. MEDICATIONS

Medications are a very important issue for basic health units and when they are not available, on many occasions, a family cannot go and purchase the medications needed for the patient. However, when the basic health unit has basic medications they can offer patients, the patients are even more satisfied with the attention received. The list of basic medications reviewed included: Acetaminophen (oral suspension 120mg/5ml, 80mg tablets, 500mg tables), trimetroprim sulfametoxasol (oral suspension 240mg/5ml), Amoxicillin (250mg/5ml), penicillin benzathine (1.2 million UI/Dil 3ml), erythromycin (250mg/5ml), Vitamin A (drops 50,000, 100,000, 200,000 UI), Albendazol (200mg/5ml), mebendazole (100mg/5m), ferrous sulphate (oral suspension 125mg/5ml), chloroquine (150mg tablets), primaquine (5mg tablets), Salbutamol (oral suspension), Oral Rehydration Salts, and folic acid (tablets). Most clinics had ORS (40%), followed by acetaminophen oral suspension 120mg/5ml (28.9%) and trimetroprim sulfametoxasol oral suspension 240mg/5ml (28.1%). The medications less used by the health promoters and were less stocked were primaquine 5mg tablets (1.5%) and chloroquine 150mg tablets (3.7%) as these can only be used at health services and are not distributed to the health promoters. Folic acid in tablets was available at 9.6% units, and is less stocked. To determine the supply of medications available the promoter was asked directly what they had in stock and this was then confirmed through a manual inventory of the shelves where the medications are located.

In regards to the time frame in which basic health units receive supplies, 45.9% receive them only when the Ministry of Health can provide them, 20% are supplied monthly, 18.5% are supplied quarterly, and 11.2% only during harvest (when the migrant population at arrives at the farm) and 4.4% when the supplies run out.

G. ATTENTION TO PATIENTS

A total of 50% of the patients at the basic health units are attended upon request by the promoter, 46.1% of the promoters attend on a daily basis, and 3.9% attend 2 or 3 times a week. In regards to the daily working hours, 46.7% work only when they are sought out by patients, 23.7% work 1 to 3 hours, 17% work 7 to 9 hours, 11.9% work 4 to 6 hours every day and 0.7% attend only in cases of emergency.

III. PARTNERS

A. STRENGTHENING OF BASIC HEALTH UNITS

From the results it was determined that in regards to owners and/or managers of the farms, 46.7% provide facilities, 45.9% provide furniture, 26.7% provide equipment, 17.8% provide medicines, 39.3% provide maintenance to the basic health unit, 37% provide a vehicle for transportation or emergencies and 43.7% do not provide any type of support.

B. STRATEGY SUPPORT

In regards to support for the strategy from the farm or community, 41.5% have participated in meetings or assemblies, 11.9% have hired health staff to support the health promoter during harvest time or for specific activities, 41.5% provide incentives to the promoter (travel expenses, paid leave to attend training sessions, etc.) and 46.7% do not participate.

C. SUPERVISION BY MOH–IGSS-HOPE

In regards to the supervision performed by the Ministry of Health, 44.4% of the promoters indicated they had not received a supervisory visit in the last three weeks, 30.4% have received one visit, 15.6% have received two visits and 9.6% have received three. From Project HOPE, 32.6% have received one visit or none in the last three months, 25.2% have received two and 9.6% have received three. From the Guatemalan Social Security Institute, 47.1% had not received a visit in the last three months, 11.8% had received one or two visits and 29.4% had received three visits.

D. MEDICATIONS PROVIDED BY THE MINISTRY OF HEALTH

When reviewing the medications provided to the basic health units it was determined that 81.5% are received via the Ministry of Health, 16.3% are provided by the farms and 2.2% are channeled via a NGO under the increased coverage strategy (SIAS). These results are obtained independently from each medication supplier, and some basic health units are supplied by several sources and some only by the Ministry of Health.

E. SUPPLY OF FORMS FOR REPORTS

In regards to the supplies of forms for reports by the Ministry of Health, 34.8% have received the required forms once in the last three months, 32.6% received them three times, 17.8% have not received forms in the last three months and 14.8% have received them twice.

F. ATTENTION OF THE MINISTRY OF HEALTH TO REFERRALS

A total of 63% of the promoters interviewed confirmed that their referrals are attended to at the Ministry of Health services, 27.4% responded that they are sometimes attended, and 9.6% are not attended. The volunteers have felt at times that their work is not valued and referral and counter referral does not take place as 86.7% of those interviewed confirmed they did not receive counter referrals, which means they do refer patients but do not know if they were attended, if they were correctly diagnosed and what treatment was provided to the patient in order to follow-up. Only 13.3% receive a note on follow-up required for the patient.

G. HEALTH ACTIVITIES ORGANIZED BY PARTNERS

In regards the activities organized for the population, the following were reviewed: the Ministry of Health conducted health activities on the farm or in the community of over the last six months (50.4%), the Ministry of Health/IGSS conducted health activities on the farm or in community during the past year (39.3%, the farm or community has made improvements to the environmental conditions (38.5%, the Ministry of Health/IGSS visited wards or homes to detect sick children (27.4%) and no activities were organized by the Ministry of Health/IGSS on farms or in communities (27.4%).

IV. SATISFACTION WITH THE PROMOTER

This fourth item in the questionnaire for the assessment of the situation of basic health units included open questions for personal comments from the health promoter on their perception of themselves in the basic health unit. Among the comments received it is noted that they are happy and content with their role because they are learning about illnesses and are able to help families, in spite of the limitations they experience, they are motivated to help people and participate in meetings, and thus learn many new things. They are happy because they enjoy their work, people trust them and there is much to do to help people. One of the aspects mentioned is that they enjoy helping needy migrant populations and in spite of their limitations they try to do the job to the best of their ability, and are thankful to Project HOPE and the Ministry of Health who have allowed them to help people and receive training.

In regards to the problems they experience while performing their job, the promoters mentioned: in some cases there are not problems, in others they observe that the basic health unit is very small and when there is a lot of work it is difficult to attend to the patients, lack of medications, furniture and equipment, there is not much time to work in

the basic health unit because they also have to do their regular work on the farm, many times they are allowed to attend meetings, the basic health units do not receive maintenance and in some cases have leaks, they cannot provide injections, they do not receive support from the farm, people do not participate in the meetings, they have difficulty organizing meetings, they are nervous, they have trouble filling in the paperwork, they do not have money to travel and are too far to walk, do not know about family planning, do not have water at the basic health unit, during harvest season they have many patients and not enough time to attend all, they are working alone and have trouble reading, they are no longer hired by the farm and are volunteers without a job, the people do not know them, the husband does not want them participating in the training as they have to take care of their small children, and are not trained in AIEPI.

Per the comments made by the promoters in regards to what can be done to improve the work of the basic health units: in some cases they consider they are functioning well and do not require any changes, others said they could operate better with adequate equipment, furniture and facilities for the patients, some require larger facilities, more medicines, more training, they would like to receive greater support from social institutions, they require a larger economic incentive in order to participate in the programmed meetings as they cannot afford the transportation costs, they would like to work fulltime attending patients in the basic health units, would like to receive more supervision from the Ministry of Health and Project HOPE, have more meetings with the population so they are familiar with the promoter at their basic health unit, painting of the basic health units, they require more comfortable facilities, an ambulance and first aid kits.

Conclusions and Recommendations

I. PROMOTER PERFORMANCE

- One of the results of the democratic opening in 1996 when the Peace Agreements were signed was the greater community participation on health. After a gradual decentralization process of some health services, the Integrated Health Care System (SIAS) aimed to operationalize this policy with the incorporation of NGOs and other public and private services, together with the appointment of health wardens at community level.
- The opportunities for migrant workers to obtain significant remuneration is limited up to a point, which is why they migrate in search of ways to increase their food and nutritional security, as at the same time that coffee is harvested the corn crop reserves are at their lowest in the highlands.
- The epidemiological profile of this population is dominated by infectious and parasitic illnesses, especial diarrhea, acute and chronic respiratory infections in addition to malaria, dengue and oncocercosis (this last in endemic zones such as Suchitepequez). According to a report of the IGGS the most common illnesses affecting the migrant population are: diarrheal and respiratory diseases, sunstroke and work-related accidents.

- The scaling-up of the coverage of health services via basic health units is an institutional modality to facilitate sustainable access to basic health services for the unprotected resident and migrant child-mother group. These community centers providing extended coverage (basic health units) are located on coffee farms in areas of the Boca Costa that have been selected and prioritized by the health services according to the following criteria: coffee is the main crop, approval of the owner and/or manager, hiring of migrant workers during harvest season and priorization of health coverage in the municipality. The strategy originally was created to implement basic health units on farms where the migrant population arrives to harvest coffee, but due to the drop of coffee prices many farms have been sold or no longer produce coffee, which has caused the population to transfer to basic health units in neighboring communities or communities where the demand for services is higher. Some additional crops that the farms produce include: tea, papaya, rubber, plantains, banana, macadamia, mangosteen and quina. Under this model for scaling-up institutional coverage, support is required for the implementation of community centers (basic health units) by private institutions, the Ministry of Public Health and Social Assistance and Project HOPE.
- The Ministry of Public Health has an established a Management Information System (SIGSAS) and it was noted that many promoters use notebooks specifically designate for registering cases, most likely because they do always have the necessary stationery provided by the Ministry of Health. It may also be possible that in spite of the training received, they still find it difficult to register the information. Due to this a test is being made with the use of a registration form for children under 5 years old per the AIEPI IMCI strategy, developed and implemented by the PROREDES program as a modified information system tool of the Ministry of Health and adapted to AIEPI to facilitate the work of the promoters.
- To determine the number of visits made to basic health units the SIGSA was reviewed and the notebooks where the registrations are made. In cases where there were no patients because the promoter had to leave the farm or community or had a lot of work and not enough time to attend the basic health unit, a plan needs to be defined so that the health promoter can attend the basic health unit every day and thus satisfy better the needs of the families on the farm or in the community.
- The constraints affecting the attention of patients include: availability of the health promoter, the conditions in which they are working, their daily work and the support received from the partners or the community. This implies that the implementation of the strategy needs to be strengthened in the basic health units via meetings with partners so that they can provide increased support and facilitate the strategy implementation for the health promoters.
- In regards to participation in the follow-up meetings, it was noted that great communication is required for the persons responsible for organizing the meetings so that the owners and/or managers of farmers are aware of the activities in which the health promoters should participate as their presence is required to ensure their

skills are updated periodically. At the monthly follow-up meetings topics are discussed that have previously been included in the AIEPI strategy but due to their importance need to be emphasized and strengthened.

- For poor families, and even for others, the expense related to illnesses and death can be catastrophic, either resulting in the reduction of income for other needs and/or utilizing the resources of information production units in which one out of every two people is economically active. One way to guarantee access to health services regardless of their immediate capacity to pay is via the fulfilling of commitments made by the partners and health promoters to ensure the health of resident and migrant families.

II. BASIC HEALTH UNITS

- The efforts made by the health promoter to provide services in the basic health unit are important, as in addition to time they also provide a physical area in their home so the patients can be comfortable. The recommended location for the basic health unit is a designated facility provided by the farm or the community with set conditions, and in cases where the basic health units have been implemented in communities they should guarantee a community facility for the attention of patient that meets the previously established requirements. However, due to lack of space, the health promoter has assumed the responsibility by setting-up the basic health unit in their home.

- In spite of the fact that the location of the basic health units is not optimum, the conditions in which they are kept are satisfactory. That is, the health promoter is interested in providing good attention to the patients who seek them out, in compliance with the minimum guidelines for the implementation of the units.

- It has been established that the minimum equipment required for the basic health units include: timer, oral thermometer and scales. However, not all possess all this equipment and a strategy should be identified to supply this equipment to health promoters so they provide higher quality attention.

- The minimum furniture required by a basic health unit include: stretcher, tables, chairs, shelves for storing medicines and screens or curtains. In the case of the stretcher, it was considered as such as long as the patients were able to lie down while being checked by the health promoter. In several cases the furniture is used both for patients at the basic health units and also for family use when the units are located in a health promoters home and there is no specific space for one activity or the other.

- It was observed that the use of materials has not been simple in spite of the fact that they have been specially adapted. Further counseling is required for their identification with real cases, through practice, and their use and comprehension.

- Since 1997 the country does not possess a policy for setting prices, and we are at the mercy of the market. Even though the open competition has not lowered prices for the user, the availability of basic medicines distributed by the State has improved at various levels. This is the result of negotiating larger volume, paying suppliers upon receipt of product, elimination of corruption circles and the creation of a network of Social Sales for Rural Medicines and Kits in the communities participating in the scaling-up of coverage. In addition, the creation of the Program for the Accessibility of Medicines (PROAM) has enabled social sales and rural stores to purchase medicines with great savings. This has permitted greater accessibility of the basic medicines in the most over-looked communities. The results reflect that there is a great need for the medicines required for patients at the basic health units located in the area of the Boca Costa.

III. PARTNERS

- Several contributions are required from partners for the implementation and operation of the basic health units, namely the owners and/or managers of the farms, the Ministry of Health, Guatemalan Institute for Social Security and Project HOPE. These contributions were reviewed in this assessment. It is important to strengthen the support received from the owners and/or managers of the farms so that the basic health units can fulfill the purpose for which they were created.

- In regards to the support required for the strategy, many aspects must be strengthened jointly by the partners in order to further benefit the families seeking attention at the basic health units located on the farms and/or in the communities.

- The visits from the Ministry of Health need to take place periodically in order for health promoters to feel supported, and to ensure that any questions or doubts regarding procedures to be performed or problems arising are dealt with in a timely manner and thus avoiding complications. The supervisory visits to the health promoters at the basic health units need to be coordinated between the three partners involved to ensure they fulfill the purpose for which they were created.

- Due to the fact that medications are very important for integrated attention at the basic health units, it is necessary that the timely and adequate supplies of medications is programmed in order to avoid a lack of medications, and to also ensure availability of basic treatments included in training of health promoters. Project HOPE provides medications only when a special donation is received, at times when the Ministry of Health has run out, and during harvest season, as a means of providing support as there is not a supply commitment on their part, as these should be provided directly by the Ministry of Health and the owners and/or managers of the farms for their sustainability.

- The preparation of patient reports at the basic health units is of great importance as they reflect the demand for services not covered by the health services such as

centers or posts, and the supply of medications is determined on the demand for services. The morbility analysis is determined via the patient reports from the basic health units for appropriate actions, and if the forms required are not available this information is lost, not to mention the opportunity to act in a timely manner.

- In regard to the attention of referrals by the Ministry of Health, health services staff need to be sensitized on the importance of the work performed by the health promoters at the basic health units on farms and in communities, and in many cases they do not accept the counter referrals.

- The strategy partners for the implementation of the basic health units need to promote the organization of activities with community projection, as this is a way to strengthen the role of the basic health units on the farms or the communities where they are located. In addition, the population will observe the importance of the role of the health promoter within the strategy.

IV. PROMOTER SATISFACTION

- The comments made by the health promoters interviewed reflect their feelings and their commitment to working to benefit the families of the communities, in spite of their financial constraints. These comments should be considered so that the situation of basic health units improves and the health promoters can provide a better service and support health education in the community.